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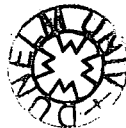
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**The Role of Emotions in Training and Clinical  
Supervision of Professionals Working in  
Community Mental Health Services:  
An Exploration of the Lazarus Model**

**A thesis submitted to Durham University for the Degree  
of Doctor of Philosophy**

**By  
Chiara Lombardo  
School for Applied Social Sciences**



**2007**

**1 1 JUN 2007**

*Per aspera ad astra*

(Seneca, *Hercules furens* II act, v. 437)



## **Abstract**

Many mental health professionals trained in psychosocial interventions (PSI) do not implement their newly acquired skills with clients. One reason for this may be the role that emotions play in training and its transfer. Therefore, the Lazarus (1991) model of emotions provided the theoretical background for this study.

## **Objectives**

The objectives of the research were to:

- 1) Describe the experience of emotions in training and transfer
- 2) Operationalise the Lazarus model, so as to measure emotions in training
- 3) Test the model, through an investigation of the possible interactions between stress, coping and emotions experienced by mental health professionals in the transfer of their learning into clinical practice.

## **Hypotheses**

- I. Emotions play an important role in both the acquisition and the transfer of new skills in a professional setting.
- II. The use of coping mechanisms facilitates the process of learning new clinical skills and their transfer

## **Methods**

To achieve these objectives and to test the hypotheses, different methods were used.

A semi-structured interview was constructed and administered to twenty-one mental health professionals. Data were analysed using an inductive content analysis a questionnaire was then constructed and administered to 102 trainees receiving PSI training. Links between emotions, training and transfer were assessed through bivariate correlations.

Lastly, a multiple baseline design was implemented; data were collected through a daily diary from 4 supervisees. The implemented intervention consisted of “revitalised clinical supervision”. Data were analysed using visual inspection of graphs, and autoregression analysis.

## **Results**

Analysis of the interviews suggested that emotions are present in training and transfer. The questionnaire data showed some positive correlations between emotions felt during training and those experienced in transfer. Finally, no effects of the intervention were found.

## **Discussion**

Although the presence of emotions in training and transfer was demonstrated, the small sample size did not allow rigorous testing of the hypotheses. Regarding the third study, different explanations why the intervention had no effect are discussed. However, the results suggest that a multidimensional approach should be taken into consideration, when studying training and transfer.

## **Conclusion**

The study could help to maximise transfer of training and supervised practise, improving the cost-e

### **Statement of Originality**

This research was undertaken while the author was an Assistant Psychologist in the Centre for Applied Psychology of Newcastle University, and then when I was a Research Assistant in the Centre for Applied Social and Community Studies, at Durham University.

Some of the material presented in this thesis was part of a wider research project on improving Clinical Supervision. I am specifically responsible for constructions of the instruments and for the data collection. I carried out the analysis of all the data presented in this thesis.

## ACKNOWLEDGMENTS

I am indebted to my Supervisor, Prof. John Carpenter. His guidance has been consistent and solid. I am also very grateful to Prof. Derek Milne, from the University of Newcastle, where this research started. Derek was my first supervisor; his help and support have been invaluable. Derek is also responsible for the design of the investigation described in Study 3.

I also would like to thank Prof. Peter Warr from the Institute of Work Psychology in Sheffield University, and Dr. David Bunce from the Department of Psychology, Goldsmiths College, University of London for suggesting some useful reading material on professional training.

I would like to acknowledge the cooperation of Brian Rowley, who has helped in the recruitment of some of the participants.

I also would like to thank colleagues from the School of Applied Social Sciences, who have been very encouraging. In particular, I would like to say a special thank you to Di Barnes, Richard Dean, Ethna Parker and Richard Wistow. They have helped me in different ways. I am particularly thankful to Dr. Claire Dickinson, a colleague and a friend, who provided invaluable support.

Without the cooperation of the participants this research would not have been carried out. I am grateful to them for the time they took to fill in the questionnaire and answer the interview questions.

Finally, thank you to my family and to my husband Filippo who has endured years of papers, books and my absence. Thank you for your patience, encouragement and support.

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# 1 INTRODUCTION

## 1.1 Background of the Study

Over the past few years there has been a proliferation of post-qualification training programmes for mental health professionals (MHPs). Training of health and social care professionals working in clinical mental health services must be regarded as a priority, if the policy for people with serious mental health problems is to be successfully implemented (Brooker, 2001). This policy, introduced by the Department of Health (DH), recognises that education and training need to be responsive to the skills and competencies required for healthcare delivery (DH, 2000). Furthermore, clinical supervision (CS) is an important aspect of continued training of MHP (Roth & Fonagy, as cited in Milne & James, 2002). The supervisees have the opportunity to reflect on their own clinical practice and the supervisor is expected to facilitate the development of the supervisee's therapeutic competence (Bernard & Goodyear, 1992). In 1997, Fadden conducted a review of family intervention studies, and identified staff training and supervision as the most essential elements determining the success of interventions. Despite this growing interest, generalisation of training represents a problem in the NHS and CS needs to be revitalised.

In order to define the generalisation problem, I will briefly review the literature on training and transfer (including CS), mainly in the applied psychology field. In addition, I will highlight the factors that facilitate or hinder the process of learning and of transferring new skills to the work place. I will then consider the notion of emotions as

an important causal variable that could help to explain the transfer phenomenon. I do so by considering a model of emotions, and the way it could be used to explain the role of emotions in training and transfer. I will also assess its suitability and adapt it where necessary (based on a careful/detailed review of the key literature).

## **1.2 Brief Overview of the Literature on Training and the Transfer of Skills and Knowledge to the Workplace**

Salas and Cannon-Bowes (2001) reviewed the 30 years since the first report on training, in the Annual Review of Psychology, and found significant progress in terms of both the science and the practice of training. In particular, recent research has focused on examining the factors that facilitate the transfer and application of newly acquired skills.

Many factors seem to be influential in training and transfer, including self-efficacy (Gist *et al.*, 1991), role-play (Littlefield *et al.*, 1999) and age (Mathies *et al.*, 1992). In a meta-analysis of training motivation, Colquitt *et al.* (2000) classified the various factors into two different groups:

1. Situational, for example supervisor support, organisational climate, and culture;
2. Personal characteristics, such as general intelligence, cognitive ability and self-efficacy.

Milne *et al.* (2000a) carried out a review of the research on the transfer of MHP training to the workplace. They identified that key factors facilitating the implementation of new skills when working with clients were: trainer support, use of experiential methods, attention to the wider work context and 'removal of barriers that impede the staff's use of the newly acquired skills in psychosocial methods' (p.268). They also identified that the

presence of these factors is an ideal condition for the implementation of new knowledge, skills and abilities (KSAs).

The problem of learning and transfer of new skills to the workplace has been widely studied, with transfer being defined as ‘the extent to which KSAs are applied, generalised and maintained over time within a job environment’ (Baldwin & Ford 1988). An important point to mention is the difference between successful training and the successful transfer of training. To consider if training has been successful, researchers have evaluated whether or not participants reached the training objectives. Transfer of training success, however, is measured against whether accomplishment of the training objectives results in enhanced job performance (Kraiger *et al.*, 1993). Clearly, if the latter is not achieved, the training is of little use to the organisation receiving it.

### 1.2.1 **The role of emotions**

In order to understand the underlying processes involved in training, studies have focused mainly on needs analysis, organisational analysis, job/task analysis and antecedent training conditions (Salas & Cannon-Bowers 2001). Research (for example Colquitt *et al.*, 2000) has supported the view that although cognitive ability is still seen as the best predictor of learning outcomes, accounting for 16-50% of the variance in post-training ability, the relationship between learning and transfer is not straightforward. Affect and skill dimensions also account for variance within training samples, emphasising their importance to learning and transfer. For example, motivation and work environment have both been found to account for 15-20%. These and other factors may help to explain why many trained MHPs fail to implement their newly acquired skills when working with

clients. The emotional dimension of learning, not to be confused with the 'enjoyment' of training, a weak predictor of training generalisation (Alliger *et al.*, 1997), has been overlooked and poorly researched. Atkins (2002) stated that 'emotional processes are crucial in learning since they involve the development of ownership, personal learning styles and abilities to convert learning into clinical, educational or managerial practice' (p.61). Cacioppo and Gardner (1999) argued that 'emotions are increasingly recognised for the constructive role they play in higher forms of human experience' (p.194). Kolb (1984) described learning as a holistic, integrative process involving feelings, perceptions and behaviours. He stated that emotions are part of the psychological mechanism that changes as a function of training and underpin learning outcomes. Emotions are a necessary part of experiential learning and such experience is thought to facilitate adaptation of knowledge. Warr and Downing (2000) conducted a study on learning strategies and learning outcomes, including self-regulatory strategies. These self-regulatory strategies cover emotion control, procedures used to ward off anxiety and prevent concentration failures caused by anxiety-linked thoughts. It appears therefore that there is some agreement that emotions play an important role in training and its transfer, although a specific model has yet to be put forward.

### **1.2.2 The cognitive-motivational and relational model of emotions**

There is no generally accepted definition of emotions, in part because they involve so many different phenomena, in other words they are multi-component phenomena (Fridja, 2000). Lazarus (1991, 2000) extended the idea of emotions, formulating them as being event specific reactions, and developed a transactional model he called the 'cognitive, motivational and relational model of emotion'. According to Lazarus, the emotional

experience is based upon a number of variables involved in the person-environment interaction. Emotions occur in response to meaning, when some sort of personal significance is placed upon a situation (Lazarus, 1991, 2000), during the cognitive interpretation of that situation.

Lazarus suggested that these three variables (cognitive, relational and motivational) are essential parts of arousing and sustaining an emotion, and without these factors an emotion is not evoked (Lazarus, 1991, 2000). This model has been thought to provide a useful framework within the training/transfer situation. In chapter 3 I will look in more details at this model and at its strength in respect to other models of emotions, in explaining the phenomena of training and transfer.

### **1.3 Literature Review Structure**

The literature review of this thesis is structured in three parts following Hart's (2005) and Rudentsam's (2001) suggestions on how to write a literature review for a thesis. These three parts of literature review appear in Chapters 2 and 3 in the following order:

- The context of the study (Government policies, PSI training);
- Presentation of the theoretical and empirical work in the extant literature; and
- Statement of the problem (transfer of newly learnt skills in MHPs).

Chapter 2 sets the context of the study and presents the theoretical and empirical studies linking training, clinical supervision (CS), transfer and emotions. In Chapter 3, I review theoretical studies of emotions and suggest how these can be applied to the training, CS

and transfer situation. Chapter 3 also provides a statement of the problem followed by the objectives and hypotheses of the study.

#### **1.4 Research Problem**

This investigation was designed as a contribution to the study of training (including CS) and the problem of transferring newly learnt skills from the learning environment to routine clinical work with clients. From the different empirical and theoretical studies examined in the literature review, it appeared that a number of variables influence learning and transfer of learning, including individual psychological characteristics. In particular, emotions have been acknowledged to play an important part in the learning of new skills. From the literature review it emerged that the Lazarus model of emotions (1991, 2000) is the most suitable to explain how emotions work in real life situations, for example where MHPs are implementing newly learnt skills in their work with clients.

#### **1.5 Aims, Objectives and Methods**

This thesis, therefore, aimed to develop a model that could describe the role of emotions in training and its transfer to the workplace, and to explore how it may be operationalised. Subsequently, this investigation had three specific objectives. The first two were related to the model development, the third was a testing of the model in a real life situation. These are described below:

1. The first objective was to check the suitability of the Lazarus model to describe the emotions experienced by MHPs when undergoing training, including CS, and in their attempts to transfer their learning into practice.

2. The second objective was to measure the emotional responses of MHPs in a training programme and investigate whether these were associated with the extent to which they were able to implement their learning in practice.
3. The third objective was to test the model through an investigation of the possible interactions between stress, coping and emotions experienced by mental health professionals in the transfer of their learning into clinical practice.

In order to achieve these objectives, I employed the qualitative and quantitative research methods described below:

1. In order to describe the experience of emotions in training and transfer, I developed a theoretically grounded semi-structured interview schedule for use with mental health professionals (MHP).
2. In order to measure these emotions, I had to operationalise and, if necessary, extend the Lazarus' model. I had then to design an instrument in the form of a self-completion questionnaire designed to measure emotions both in training and in transfer and to assess its psychometric properties.
3. In order to test the model, I worked with a colleague (Dr. Derek Milne) in the design and implementation an intervention in the form of 'revitalised' clinical supervision (RCS). Using an 'N = 1' multiple baseline case study design with a self-report daily diary, I assessed the effects of the intervention in a 'real life' practice setting.



My hypotheses were that:

III. Emotions play an important role in both the acquisition and the transfer of new skills in a professional setting.

IV. The use of coping mechanisms facilitates the process of learning new clinical skills and their transfer

Table 1-1 summarises the objectives and methods. The work undertaken to achieve each of the three objectives is, for convenience, referred to as Study 1, 2 and 3 respectively.

The table also indicates the participants in each Study.

**Table 1-1 Objectives and methods of the study**

		Objectives	Methods and measures	Participants
Model Developing	STUDY 1	Describe the experience of emotions in training, CS and transfer: is the model suitable?	Semi-structured interviews to explore the nature of emotions in training, CS and transfer	Mental health professionals (N = 21) undergoing learning experiences (e.g. professional training or clinical supervision)
	STUDY 2	Measure emotion as described by Lazarus (1991) and its associations with transfer	Affect in Training Questionnaire, designed to measure emotions both in training and transfer Generalisation Questionnaire, to measure transfer	Mental health professionals (N = 102) undertaking post-qualifying training
Model Testing	STUDY 3	Test the model through an investigation of the interactions between stress, coping and emotions experienced in CS and transfer	Daily Coping Diary to record possible effects of an intervention on coping, emotions and transfer.	Mental health professionals (N = 4) participating in clinical supervision

## **1.6 Thesis Structure**

The thesis is presented in a number of chapters and a brief overview of each chapter follows below.

In Chapter 2, I will introduce the problem of the transfer or generalisation of new learning for MHPs. I will focus on the outcomes of such training, and I conclude with a section on the main theoretical issues related to learning and transfer. I will then present the main studies that have introduced the idea that emotions may play an important role in training, CS and transfer.

In Chapter 3, I will describe some of the most relevant theories of emotions; in particular I will explain the Lazarus model (1991), and propose how it could be applied to training and its transfer.

In Chapter 4, I will introduce the methodology used in this thesis and justify the design of each study, the methods and the instruments.

I will describe the methods and procedures used in the three studies which comprise the project.

Chapter 5 presents the results of the three studies and chapter 6 is a general discussion of the results obtained. I will also draw the attention on some of the limits of this research before suggesting how its findings might be applied in the training and supervision of health and social care professionals working in mental health services.

## **1.7 Conclusions**

This chapter has laid the foundations for the thesis. It has introduced the research problem, the aims and objectives of the thesis research and stated the hypotheses. The methodology has been outlined and the structure of the thesis described. A detailed description of the background, methodology, findings and implications of the research follow.

## 2 THE PROBLEM OF TRAINING AND TRANSFER IN MENTAL HEALTH

The thesis begins with a review of the literature on the post-qualifying training of health and social care professionals, drawing attention to the problem of transfer of the skills learned during training to mental health work in practice.

### 2.1 Literature Search Strategy

The literature search was conducted following the five major modes proposed by Cooper and Hedges (1994):

1. Footnote chasing, this is defined as ‘the use of other authors’ references to the prior literature on the topic’ (p.46, 1994).

As suggested by Cooper and Hedges (1994), this was done at the beginning of the search. First, I collected some references and publications from an ongoing research project led by my supervisors, in which I was working as a research assistant (Carpenter *et al.* 2007). Then, always following Cooper and Hedges’ (1994) suggestions, once the key papers were identified, I ‘followed up leads to earlier work from their reference section’ (p.46).

2. Consultation, asking experts.

Experts who had published previous work in the area were also consulted either in person (where possible) or via email. These experts are noted in the Acknowledgements.

3. Searches in subject indexes.

Electronic searches of a database were carried out. The database Web of Science and Psyc INFO were searched, using the keywords 'emotion' (including the variations: emotional and emotions), 'mood', 'training', 'clinical supervision', 'transfer of training' and 'learning' and 'mental health professions' in various combinations. The inclusion criteria were:

- a) Articles published in scientific journals, in English after 1997 following Hart's (2002) suggestion to restrict the search to articles and books published during the last six years.
- b) Relevance: including similar participants and training programmes; related methodologies and instruments; related findings or theories.
- c) Satisfactory quality: some papers were excluded when judged to be of poor methodological quality, but no formal rating system was utilised.

Hart (2002) advised that textbooks are useful to obtain a 'general overview of a topic or a discipline highlighting main ideas, developments and authors' (p.94). The same keywords were therefore used to search for books in OPAC (Online Public Access Catalogue).

#### 4. Browsing.

Relevant journals (e.g. Journal of Applied Psychology) in the University collection were browsed both manually and electronically (e-journals). Textbooks on emotion, learning and training and transfer were consulted.

#### 5. Citation searches.

Once I identified the names of the authors that published most frequently in the area of training, transfer and emotions, I conducted a computer search of the Social Sciences Citation Index. I was particularly interested in findings work published by Lazarus.

## **2.2 Findings**

The present chapter is divided into three main sections, beginning with a review of the policy background. Whilst theory may support the premise that training can have positive outcomes for those who work in mental health services, there is a need to examine the evidence supporting this premise.

The second section focuses on the outcomes of such training and evaluates those individual factors that hinder the learning process and the implementation of skills and knowledge gained through training in practice with mental health service users.

In the third section I will review some theoretical issues related to the learning process and to transfer. I will define some of the most widely used terms; then I will introduce some of the most well-known theories of learning. Finally, particular attention will be given to those studies that have considered emotions as having an important role in training and the transfer of learning.

The next chapter (Chapter 3) presents the theoretical studies of emotions and I suggest how these can be applied to the study of training, CS and transfer. I also present the research problem and the aim, objectives, and hypotheses of this investigation.

### **2.3 Policy Background**

The DH (2000) stated that

‘we spent some £2 billion a year supporting training and education for clinical staff [in the NHS generally] - and more money is spent locally on staff development and training. We need to make sure that we plan and develop the NHS workforce, and use our investment in it, to deliver the best, most effective, care for patients’ (2000, p.5).

It then appears that modernising education and training is one of the priorities of the NHS, in order that staff be provided with the skills they need to work effectively. Government policies have emphasised that, in order to have effective treatment, levels of knowledge and investment in training have to be improved.

‘[...]what matters is that staff are trained, organised and managed properly to ensure that the effective interventions are delivered where they are most needed and where they can have most impact’ (DH, 1998, p.45).

The Government’s mental health strategy (Modernising Mental Health Services; safe, sound and supportive, 1998) stated that MHPs should be properly trained to provide ‘evidence-based’ interventions, to people with severe and enduring mental health problems living in the community (1998, p.35). In 1999, the Government produced the National Service Framework (NSF) for mental health (DH, 1999). The NFS outlined different standards of service; this led many to comment on the need for training, in order to enable the mental health workforce to meet the standards and service models

identified. For example, a report by the Sainsbury Centre for Mental Health (2000) contended that

‘the NSF has significant workforce implications. Its aspirations cannot be delivered without a combination of increased numbers of staff and the rapid enhancement of skills and competencies’ (p.15).

The NSF also argued that it should include training in evidence-based psychosocial interventions (PSIs) for those experiencing severe mental health problems (DH, 1999, p.111).

There is significant evidence of the effectiveness of psychological therapies. Training in psychosocial interventions (including cognitive behavioural therapy (CBT) and behavioural family therapy) is, in general, well accepted by trainees, service users, families and policy makers (Brooker, 2001). However, despite this growing interest and investment of money, some problems in application have been identified. As I will discuss below, the limited implementation of the knowledge and skills offered by MHP training has been a concern, with various authors identifying barriers to the implementation of training.

## **2.4 Psychosocial Interventions**

Evidence based psychosocial interventions (PSIs) are psychologically based therapies for people with severe and enduring mental health problems. They include CBT for



psychosis and severe anxiety and depression (Tarrier *et al.* 1998), family interventions (Fadden, 1998) and psycho-education for users and/or carers (Barrowclough *et al.* 1987).

According to Brooker (2001), the evidence for the effectiveness of PSIs has been reviewed widely. Some studies have demonstrated that psychotic and affective symptoms can be reduced using cognitive behavioural treatments (Tarrier *et al.* 1998). CBT is based on the assumption that cognitive and environmental processes influence symptoms or problems and that they can be modified by the use of cognitive and behavioural skills (Haddock *et al.*, 1998).

Family intervention 'has been shown to be effective in reducing relapse and admission to hospitals when implemented after first episodes of illness or subsequent relapses' (Scottish Intercollegiate Guidance Network, 1998, p.7). In family intervention approaches, the therapist should establish a collaborative relationship with all the family members, using a positive non-judgemental approach. The therapist aims at helping the family to find ways of coping with the illness (Fadden, 1998).

Early diagnosis and early intervention in schizophrenia and other serious mental illness have also received much more attention in recent years (Birchwood *et al.*, 1990). In 1991, Lam reviewed four major controlled studies that demonstrated that the rate of relapse in schizophrenia can be reduced when families receive a PSI package, which comprises assessment of each family member's needs, information about schizophrenia and family stress-management programmes. Birchwood (1996) provided evidence that identifying

relapse in its prodromal stage and providing pharmacological treatment can reduce the severity of a subsequent relapse and reduce re-hospitalisation rates. Arguments have been made for more intensive intervention for first episode clients and the development of more systematic ways of identifying a client's individual relapse signature (Initiative to Reduce the Impact of Schizophrenia, 2000).

Despite evidence of the effectiveness of these psychosocial interventions they are still not commonly available in practice, as will illustrate in the paragraphs that follow.

## **2.5 Training and Changes in Behaviour**

According to Brooker (2001), more than 30 undergraduate and postgraduate programmes in PSIs were established during the last decade. However, long-term studies that have evaluated the PSI training programmes suggest that there are real problems with the implementation of PSI knowledge and skills in mental health services provided by health and social care agencies, such as community mental health teams.

Bailey *et al.* (2003) conducted a literature review of post-qualifying mental health training. Their research literature was classified in terms of the study design and level of outcomes of the training assessed. The authors used Kirkpatrick's framework for training evaluation (1967), as extended by Barr and his colleagues (Barr *et al.*, 1999). Bailey *et al.* (2003) identified four levels of training evaluation. Level 1 includes learners' reaction, which relates to trainees' 'views of the learning experience and satisfaction with the training' (2003, p.11). Level 2a incorporates modification in attitudes and perception;

‘outcomes here relate to changes in attitudes or perceptions towards service users and carers, their problems and needs, circumstances, care and treatment’. (2003, p.11). Level 2b, acquisition of knowledge and skills, covers ‘the concepts, procedures and principles of working with people with mental health problems. For skills, this relates to the acquisition of thinking/problem solving, and intervention skills and skills linked to multidisciplinary working’ (2003, p.11). The third level of training evaluation consists of changes in behaviour. This includes the transfer of the acquired knowledge into routine work ‘prompted by modifications in attitudes or perceptions, or the application of newly acquired knowledge and skills environment’ (2003, p.11). Level 4a involves the changes in organisational practice, which can be associated with a training programme. Finally, Level 4b relates to benefits to users, which includes ‘any improvements in the mental health and well being of people who are using services as a direct result of an education program’ (2003, p.11).

For the purpose of this thesis, I will focus on changes in behaviour, in order to identify potential problems with the implementation of PSI skills when working with clients. This level covers the implementation of learning, in other words, trainees putting their newly acquired skills, knowledge or changed attitudes into practice.

From Bailey *et al.*’s (2003) review, it seems that much of the evidence for change in trainees’ behaviour, following courses in PSIs is weak. First of all, there is a heavy reliance on self-report surveys. Many of these studies offered evidence of problematic implementation of the trainees’ learning in their routine clinical practice. For example,

Milne *et al.* (2000b) conducted an independent evaluation of an eight-day training programme in PSIs. In order to assess change in behaviour, they designed a generalisation questionnaire. Respondents were invited to note which of a list of 13 PSI methods and associated assessment measures they had used in the three months before and after the training programme and the number of clients with whom these PSI approaches had been implemented. Trainees also had to rate the clinical impact of their work: the 'generalisation across behaviours, persons and responses' (2000b, p.94). Lastly, they rated the support received for the PSI approaches from a list of 13 different sources, for example peers and the agency supervisor.

Trainees reported significant increases in the use of seven of the 13 PSI instruments and methods, comparing the three months before with those after the training programme. Nineteen of the 45 trainees (42%) reported using the PSI approaches with an average of nine clients, in the three months prior to training, and assessed the clinical impact as 'moderate'. However, no implementation data are reported for the remaining 26 trainees (58%). This, together with the fact that all data are self-reported, means these findings must be considered as providing only weak evidence of implementation.

Bailey and colleagues (2003) reported on a series of studies undertaken by Brooker and colleagues. In the first study, Brooker (1990) conducted a survey with trainees and the managers who supported them. Trainees were attending a training programme for CPNs, between 1980-1986. Of the managers who responded, 66% reported that they had observed positive differences in the CPNs' work after the completion of training.

However, 28% of managers highlighted some problematic areas in the students' work on their return to the service. These reports included no change in the students' attitudes and skills and a continued desire to work in a hospital, rather than from a community base. Similarly, one third of students who responded reported that they had not introduced any changes in their practice on their return to their seconding health authority.

In a further study, Brooker and Butterworth (1993) evaluated the behaviour of eight trainees on a 17-day, part-time programme spread over six months, aimed at training CPNs in PSIs. They used the aspects of CPN organisation and practice questionnaire (AOQ). This instrument was designed to measure changes in the way trainees organise their work, for example, case-load numbers, percentage of users with a diagnosis of schizophrenia, degree of support and relationships with referring agencies. The authors found very few significant changes in behaviour, from the start to the end of training. There was a significant increase in the proportion of time during the working week spent working with families before and after training (15% and 45 % respectively). The number of intervention hours per family given by the CPNs each month also increased significantly. Trainees considered that most of their support, locally, came from psychiatrists and psychologists rather than their own managers.

In conclusion, from the studies described above, it looks like changing behaviour, and the transfer of knowledge in the workplace can be a difficult process. In the paragraph that follows, I will describe some of the most common factors that prevent people from changing their behaviour and implement newly acquired skills with their clients.

### **2.5.1.1 Barriers to implementation**

In the previous section (2.3) I stated that different barriers prevent the implementation of skills learned in training when working with clients. I will now present some studies where these barriers have been explored.

Bailey *et al.* (2003) identified three studies, conducted respectively by Repper (2000), Carpenter *et al.* (2003) and Brooker *et al.* (2001), which described possible barriers to the implementation of PSI training. I will now summarise and comment on these studies.

Repper (2000) evaluated a multidisciplinary training programme in PSIs for those who work with people who have serious mental health problems. This was a one-year postgraduate certificate course. Semi-structured interviews were conducted with seven trainees. These semi-structured interviews aimed at understanding the nature of trainees' work with clients and to understand not only what trainees did, but also why they did it. Although trainees reported using a greater range of skills after training, potential barriers to implementation of the newly acquired skills were identified. These included:

- Inadequate teaching or supervision;
- Lack of confidence;
- Perceived lack of relevance to the clients;
- Isolation;
- A lack of support and understanding in the workplace;
- Large caseloads;
- Lack of time; and

- The failure of services to enable them to work out of hours.

However, Repper (2000) argued that, in comparison to similar studies of training in PSI, these students may have been less motivated than other sample groups and then had perceived greater barriers.

Carpenter *et al.* (2003) reported data from successive cohorts of students, mainly Community Psychiatrist Nurses (CPNs), social workers and occupational therapists (OTs), attending the Birmingham University Programme in Community Mental Health. Trainees were asked to rate the extent to which they used PSIs. The first cohort of trainees completed a series of scales at the end of the first year and the end of the second year of the programme. The second, third and fourth cohorts of students completed the scales at the start of the programme and at the end of the first year. All the respondents reported statistically significant increases in their use of various PSI skills. In order to evaluate difficulties in implementing learning when working with service users, Carpenter *et al.* (2003) used the Barriers to Implementation Scale (adapted from Corrigan *et al.*, 1997). This scale is made up of five subscales, which measure perceived difficulties relating to time and resources, support and interest of colleagues and managers, user and carer beliefs, knowledge, skills and supervision, and trainees' beliefs in PSI. The barrier consistently given the highest rating by successive cohorts of students was *lack of time and resources*. In most cases, barriers were perceived as decreasing. However, with the fourth cohort of trainees there was a statistically significant increase in the sub-scale that measured *knowledge, skills and supervision* by the end of the first year.

Group discussions with the trainees helped to clarify this result. Respondents reported that they felt the *teaching* was not of sufficient depth to enable them to use PSIs. They also felt that they *lacked the sufficient skills or confidence* to implement the interventions.

The third study identified by Bailey *et al.* (2003) was that of Brooker *et al.* (2001). This study put more emphasis on the organisational factors, and compared the views of trainees and their managers. The authors reported a follow-up survey of trainees attending PSI programmes in Sheffield and London. They surveyed trainees concerning their views on their acquisition and use of PSI knowledge and skills. Respondents reported a highly significant increase in their use of PSI approaches. Both trainees and managers of each group rated barriers to implementation, across three broad areas: resources, skills and relevance. Managers and trainees agreed on the order of difficulty each item posed, but managers rated barriers as being higher than did the trainees. The main obstacles were

- Caseloads being too large;
- Other people not understanding what was involved;
- Not enough staff trained in PSI; and
- Lack of an organisational plan or strategy.

In contrast to the two studies described above, Brooker *et al.* (2001) included a sample of managers, thus providing a wider picture of the training context, including the organisational level.



More recently, in an evaluation of a two-year part-time PSI programme Carpenter *et al.*, (2007) used a modified version of the Barriers to Implementation questionnaire described above (Corrigan *et al.*, 1997) to measure the perceived factors that hindered the implementation of the training. The study was conducted on two cohorts of trainees. The results showed that when the course started both cohorts indicated that the highest perceived barriers were as follows:

- Insufficient time and resources (this was the biggest perceived barrier);
- Trainees' knowledge and skills; and
- Users' and carers' beliefs.

However, at the end of the first year of training these two barriers (trainees' feelings that they had insufficient time, knowledge and skills the trainees' view that some service users and carers did not believe in the efficacy of the interventions) decreased (these results were statistically significant). The second cohort reported similar results. At the end of the second year of the PSI programme, trainees were again asked to complete the Barriers to Implementation questionnaire. No significant differences were found, apart from the perception that users and carers did not believe in the interventions. The second cohort of students reported the same pattern of barriers at the start of the course, but to a lesser extent. Changes in Cohort 1 on the barriers questionnaire at the beginning and end of the year were compared to those for trainees who attended a similar training programme at Birmingham University (this study, by Carpenter *et al.* 2003, has been described above). The Northern region had in addition to the course an organisational development programme to support PSI. The results suggested that overall perceived

barriers increased in the Birmingham trainees, and reduced in the North. However, Carpenter *et al.* (2007) felt that these differences were attributable to the course, rather than to the organisational development intervention. This study is of particular interest because it included analyses at both the individual (the trainees) and organisational levels. However, the possibility that psychological factors, for example lack of confidence, could have hindered the transfer was not considered.

Fadden (1997) illustrated the implementation problem in training in the context of behavioural family therapy (BFT). She conducted a study, in order to determine the extent to which MHPs trained in BFT techniques had been able to implement the skills learnt in their routine work environment. The data were collected from a sample of 86 therapists, who had attended a family intervention training programme. They belonged to different professional groups, and were working in various settings. They were requested to complete a questionnaire, which recorded the number of families they had been working with using a BFT approach. Participants were asked about the difficulties they had encountered, when implementing BFT in their work setting, and how they tackled this problem. There were further questions concerning the level of difficulty experienced in 33 different areas relating to services issues, clinical issues and personal issues as a therapist. They were also asked about the characteristics of the family seen, the effect of the BFT training on the therapist's work and the problems connected to supervision. Fadden (1997) stated that implementation rates were as low as 26%. She indicated a number of barriers to the use of newly acquired skills when working with clients, which are listed below. These were

- Attitudinal factors , when the approaches are in contrast with established concepts and practices;
- Diversity of interests, motivations; and
- Conflicting pressures on the organisation from outside sources.

In conclusion, studies have highlighted the difficulties trainees have had in implementing their learning. Various barriers have been identified and these can be classified in three different levels.

1. Organisational level (i.e lack of managerial support, lack of time). Commonly reported barriers to implementation appear to be related to roles at work. For example, Fadden (1997) found 'diversity of interests, motivations and conflicting pressures on the organisation from outside sources' (p.601) were a problem. Trainees had difficulties integrating the new skills into their caseloads; Brooker *et al.* (2001) highlighted a lack of managerial strategies that would facilitate trainees to incorporate the new interventions in their personal commitments.
2. Structure of the training (i.e. teaching and supervision). Appropriate supervision or teaching also appears to be a problem. For example, Repper (2000) and Carpenter *et al.* (2003) identified inadequate teaching and supervision as a barrier. (In section 2.10.2.1, I will analyse Clinical Supervision in more detail)
3. Individual level (i.e. lack of confidence). Repper (2000) identified a number of barriers, however the trainees of his study may have been less motivated compared to other sample groups, thus perceiving a greater number of barriers. Carpenter *et al.*

(2003) and Repper (2000) identified lack of confidence as one of the factors that hindered transfer. Fadden (1997) indicated that attitudinal factors (e.g. when the trainer/trainee approaches are in contrast with established concepts and practices), can limit the implementation of learning. Nonetheless, these researchers did not explore how these psychological variables (motivation, lack of confidence) might interfere with the transfer of PSI training to practice.

In conclusion, none of the studies described above investigated how these different barriers might influence each other, and in particular whether emotions (e.g. lack of confidence) play a role and if so, what role.

In the next section I will illustrate some studies that have explored possible ways of overcoming barriers to training and transfer.

## **2.6 Ways of Overcoming Barriers**

I will now present some studies where researchers have tried to solve the problem of barriers in learning. Milne *et al.* (2002a) explored ways of overcoming barriers faced by MHPs when implementing their training. Using the idea of relapse prevention in training, they conducted a pilot study in order to evaluate different approaches to training. (Tziner *et al.*, as cited in Milne 2002a) defined relapse prevention training as

‘ a way promote the transfer of training by immunising learners against the environmental obstacles to generalisation through heightened awareness, group problem-solving, realist goal setting and simulating the necessary coping skills’ (2002a, p.362).

In the study, a sample of MHPs (n=45) attending a training programme (control group) was compared to an experimental/relapse prevention group (n=11), attending the same programme, but with a relapse prevention module included. Both groups completed three questionnaires. One questionnaire aimed to measure reactions to training and was completed immediately after the training module had finished. Another was designed to measure the perceived barriers to implementation of the new skills and was completed two or three months after the follow-up period, while a third was used to assess the level of generalisation, before and after training. Furthermore, the experimental group completed a knowledge test before and after training. The results of the study indicated that the relapse prevention group reported significant differences, pre and post training on the knowledge test and also reported greater generalisation scores compared to the control group. The authors concluded that, despite some limitations of the study, the relapse prevention intervention enhanced the learning effect, thus improving the level of transfer and providing a way of overcoming barriers. It may also be the case that receiving a special relapse prevention module enhanced the motivation of the trainees.

Milne *et al.* (2004) conducted a study to explore how the work environment influences clients' access to effective therapies and to prompt research into personal and organisational barriers to training implementation. They suggested two possible ways of assessing these barriers. One of these is to analyse the determinants of innovation in the workplace, the other to ensure that a useful feedback system is in place, pinpointing areas of difficulties and approximations to the objectives of the service. In order to formulate the service, the authors adopted a relevant innovation model. Following on from the work of West and Farr (1989), Milne *et al.* (2004) considered innovation to be the intentional

introduction of desirable and novel changes within a service role, (for example staff training), designed to benefit clients. West and Farr's (1989) model of innovation at work distinguished four classes of innovation 'facilitators'. These facilitators may be intrinsic to the job, (e.g. the availability of resources), group factors, (e.g. support), 'relationships at work', (e.g. leadership) and organisational factors, (e.g. accountability issues). These four facilitators of innovation are mediated by individual characteristics (e.g. relevant skills possessed by the individual), leading to 'innovations' that results from these variables (including the implementation of new methods of working). Milne *et al.* (2004) used this model of innovation to formulate the implementation of a staff training initiative. They recruited a sample of 60 PSI-trained therapists and their 11 managers in the host Trust. Each was subjected to a structured interview specifically constructed for the study. Two versions of interview were used: one for managers and the other for trainees. Trainees were asked about the PSI methods they had been using after the end of the course and their relationship with the course. They were also asked about their level of competence and confidence, whether or not they had encountered any barriers in relation to using PSI methods, and whether or not they experienced any boosters when using PSI methods. Lastly, participants were asked to clarify their understanding of PSI implementation, through six open-ended questions, (e.g. 'how would you explain your use-non use of PSI?'). The managers' interviews followed a similar structure. They were asked about their staff's current PSI activity, and what they understood were 'barriers' and 'boosters' to the use of PSI methods by their staff. Managers were also asked to list any other factors that improved the transfer of PSI training.

Data were analysed by frequency, while the responses to the open-ended questions were analysed using a content analysis. Levels of transfer were mostly high. The top three barriers indicated by trainees were: 'integration with my caseload and other responsibilities', 'lack of resources' and 'time constraints'. Data collected from the managers corroborated these results. Both managers and trainees perceived the following boosters: 'client benefit', 'gained knowledge' and receiving 'supervision'. The qualitative data suggested that both managers and trainees had similar views. They both perceived negative facilitators, that is, they perceived there to be insufficient job discretion, unpredictability in the job, insufficient resources and an unhelpful administrative style in the organisation. Positive comments were made in relation to the 'empowering environment' and specifically as regards support within the group. According to Milne *et al.* (2004) this data indicated that, as predicted by West and Farr's (1989) model, innovations such as PSI are shaped by a range of both hindering and helpful factors. This formulation conceptualised the key variables in the improvement of treatments such as PSIs. For example, it indicates how one might assess the 'readiness' of a particular unit for innovation, such as developing PSI through staff training. This formulation can also be useful in providing feedback, and understanding on how a system is working at one particular point in time. Milne *et al.* (2004) referred to this kind of feedback as 'feedback fascia'. Managers and others who need feedback on how a system is operating might use this formulation to guide their quality assurance work.

The study of Brooker *et al.* (2001) (see p.22 above) found one of the factors associated with the successful implementation of PSI skills to be the type of service in which the

trainee worked. Assertive community treatment teams and rehabilitation teams were rated as being more prepared to implement PSI than community mental health teams. In addition, organisations that had produced overall PSI implementation strategies were also more likely to see implementation in practice. Teams also played an important role in the implementation of PSI skills, with trainees reporting a generally high level of support from team members. This increased when there was a greater percentage of PSI trained members in the team and where caseloads were smaller.

In conclusion, according to the above studies it would seem that it is possible to overcome barriers through, for example, clinical supervision, managerial commitment and continuity of training. Factors such as empowerment and support, together with the importance of receiving feedback have also been considered important.

In the next section of this chapter, I will analyse more extensively the factors that influence successful training, in particular I will consider the psychological factors that influence learning and transfer. I will also look in more detail at the role of emotion in training.

### **2.7 General Definitions of Training**

Goldstein (1993) defined training as a systematic learning experience, designed to acquire new skills, rules and aptitudes that lead to an improved performance. He also described learning as a relatively permanent change in behaviour, due to experience. It reflects a gain in knowledge, understanding or skills achieved through experience, which



may include study, instruction, observation or practice. It is a process that must be assessed indirectly: one can only assume that learning has occurred by observing performance. He also argued that the effectiveness of training originates from a learning environment 'systematically designed to produce changes in the working environment' (p.3) and to enhance job performance (Kraiger *et al.* 1993). The transfer of learning is defined as 'the process to apply knowledge to new situations' (Goldstein, 1993, p.17). The word transfer derives from Latin, where *trans* means 'across', 'over' and *ferre* means 'bear'. Literally therefore, transfer involves carrying over previous learning to new situations. In the educational and training field, training is conceptualised as the extent to which Knowledge, skills and A 'are applied, generalised and maintained in the job environment' (Baldwin & Ford, 1988).

In their review of training, Salas and Cannon-Bowers (2001) identified a number of potential issues related to transfer of training. First, the study of the training context, particularly because it sets motivations, expectations and attitudes for transfer. Secondly, the transfer climate can have a powerful impact on the extent to which newly acquired KSAs are used in the job. Thirdly, delays between training and the actual use on the job can create significant skills' decay. Furthermore, there are a number of studies on the relational environment of the training, demonstrating that social, peer, subordinate and superior support all play a central role in transfer (Colquitt *et al.* 2000).

My plan for the second part of this chapter is to introduce the training and transfer literature in order to provide a general picture of the characteristics that make training successful and to underline the role of emotions in training and transfer.

## **2.8 Historical Background to Theories of Learning**

Learning theories have been broadly divided into three categories (Rogers, 1986): behaviourist theories, cognitive theories and humanist theories. A brief description of these is given below.

## **2.9 Early Theories**

During the last century, the study of human learning was dominated by various approaches. Behaviourism, a Pavlovian view of human learning based on classical conditioning and observable behaviour, was further developed by Watson, Hull and Thorndike and reached its peak in the 1950s with B.F. Skinner's work on operant conditioning and reinforcement. This approach was criticised for its reductionism because it used a 'black box' view: since one cannot observe what is happening in the brain, one should limit measurements and theories to what is going in - the stimulus (S)- and what is coming out - the response (R). According to Rogers (1986), 'this approach tends to stress the active role of the teacher-agent; the student learner is often seen as more passive' (p.46). For example, a trainer can reinforce appropriate responses and trainees' behaviour, while discouraging unsuitable behaviours. Although behaviourist theories highlighted the importance of the stimulus and reinforcement process, which is

the basis of other learning approaches, they did not explain the role of internal factors in the process of learning.

Consequently, the 1960s and '70s saw the behaviourist movement displaced by more complex theories, such as cognitive and humanistic approaches. Growing attention was paid to the cognitive processes, and some psychologists concentrated on the thought processes that underlie learning, leading to new interpretations known as cognitive theories. As Greeno *et al.* remarked (1996), cognitive learning theories emphasise the role of general cognitive abilities, such as reasoning, planning and problem solving in understanding concepts and theories, increasing attentional capacity. 'Learning is understood as a constructive process of conceptual growth, often involving reorganisation of concepts in the learner's understanding, and growth in general cognitive abilities such as problem-solving strategies and meta-cognitive processes, defined as the capacity to reflect upon one's thinking, and thereby to monitor and manage it' (1996, p.16). In other words, the learner is seen as playing a more active role and the trainer needs to involve the trainee in a dynamic process, for example through feedback.

In 1976, Bloom differentiated between learning in the cognitive domain and learning in the affective domain, the latter facilitating the development of cognitive functions in learning. He stated that, alongside the cognitive stages in learning, the individual goes through four affective phases. First of all, the lowest levels of the cognitive domain are recall and recognition of knowledge; on the affective side this involves the reception of a stimuli, that is, a trainee is willing to pay attention to what the trainer is saying. Secondly, on the cognitive side comes comprehension, which implies understanding of the

information provided by the trainers and exploring it more actively; on the affective side, it emerges a growth of personal commitment to the training, there is a positive response and a sense of satisfaction emerges. In the third instance, on the cognitive side there is an application of the learnt knowledge, that is, using it in real situations, for example when working with clients. This is matched on the affective side by an evaluation of the worthiness of the activity, in order that, for example, the trainee decides to take part in further training or to continue on the course he or she is already attending. In other words, they value the concepts they are learning and express their preferences and commitment. In the next step, learners explore the new situations by breaking them down into their constituent elements (analysis) and by building up new concepts (synthesis); on the affect side the learners start to make judgments and assign concepts to each of the values they have identified in the previous phase. Finally, in the cognitive domain the learners evaluate what they are doing by comparing the knowledge they have acquired with their goals, for example a trainee may ask him or herself whether he or she is now competent to treat certain clients. In the affective domain they organise the values they have identified into a system, for example a positive attitude towards a newly learnt clinical technique, that in the end characterises each trainee as an individual.

The synthesis of affective and cognitive elements that Bloom (1976) brought about introduced a multidimensional perspective of learning, which authors, such as Kraiger *et al.*, (1993), have applied to the training situation, as will be illustrated later in this chapter.

The Humanistic models, which refused the view that learning processes are determined by automatic factors, suggested instead that people are in control of their lives and the learner creates the learning situation. Some theorists, like Maslow, concentrated on the affective domain and how 'learners attempt to take control of their own life processes' (Rogers, 1996, p.100), thus suggesting the importance of autonomy. The role of the trainer is to increase the range of experiences, so that the student participating can use it in such a way as to achieve their own desired learning targets, thus the trainees' goals and needs play a fundamental role. Rogers (1996) stated that we create our own learning, drawing from our ideas, feelings, experiences and evaluations about people and events in our lives; learning is not a response to a stimulus. Here the trainer is seen more as a facilitator of the process, a guide to help the trainee to understand. Participative and experiential methods seem to be the most appropriate.

In conclusion, both the cognitive and humanistic models acknowledged the importance of personal experience, but neither could formulate an adequate theory regarding its function in learning.

### **2.9.1 Current/Integralist Theories**

Recent integralist theories stress that the heart of all learning lies in the way we process experience, in particular our critical reflection on experience. Learning is a cycle that begins with experience, continues with reflection and later leads to action, which itself becomes a concrete experience for reflection (Rogers, 1996).

Kolb (1984) set out an integrative perspective on the learning process in his highly influential book entitled 'Experiential Learning: Experience as the source of Learning and Development'. The concept of experiential learning is the idea of the cyclical pattern of all learning, from experience through reflection and conceptualising to action and on to further experience.

The popularity of Kolb's model may be because rather than being an alternative to other approaches, such as behaviourism and cognitivism, it is a 'holistic integrative perspective on learning that combines experience, perception, cognition and behaviour' (Kolb, 1984, p.21). He described this perspective on learning as 'experiential' (1984) in order to underline the central role that experience plays in the learning process. Furthermore, he wanted to link his theory with the work of its predecessors, Dewey, Lewin and Piaget. These three authors described learning as a process whereby concepts are derived from and are continuously modified by experience. Six main points link Kolb's theory with his predecessors. These are described below:

1. In contrast to the behaviourist approach, Kolb (1984) put the accent on learning as a process, rather than as an outcome. Lewin, Dewey and Piaget, 'describe learning as a process whereby concepts are derived from and continuously modified by experience. No two thoughts are ever the same, since experience always intervenes' (1984, p.26); trainees, for example, continuously modify knowledge through their work with clients, and through interactions with the trainer.

2. Kolb shared with Dewey the idea of continuity: 'knowledge is continuously derived from and tested out in the experiences of the learner' (Kolb, 1984, p.27). The practical implication of this assumption is that a trainee enters a learning situation with some ideas about the topic at hand; they already have some beliefs. Consequently, by the trainer 'bringing out the learner's beliefs and theories, examining and testing them, and then integrating the new, more refined ideas into the person's beliefs systems, the learning process will be facilitated'. This is what Piaget identified as 'integration' and 'substitution' (1973).
3. Each of the three authors described learning as a process, resulting from the resolution of conflicts between opposing ways of dealing with the world, what Piaget called 'accommodation' and 'assimilation'. So, the individual's cognitive development would imply an accommodation of ideas about the external world, for example where a trainee who is learning a new approach modifies his or her existing knowledge to make it fit the new learning material. In addition, it involves assimilation of experience into existing conceptual structures, for example where a trainee tries to incorporate a newly learnt approach into his or her existing way of working.
4. They all considered learning as a holistic (Kolb, 1984, p.31) process, which includes thinking, feeling, perceiving and behaving. In other words, as will be demonstrated in this thesis, cognitive abilities, such as the I.Q., are only one of the processes that

facilitate learning and this should be taken into consideration, for example, in a training situation.

5. Learning involves a transaction between the person and the environment, each factor continuously influencing the other. When emphasising this, Kolb made particular reference to Dewey's ideas. According to this view, a trainee's learning experience is made unique not only by the material he or she is studying, but also by his or her fellow trainees, the trainer or the physical milieu.
6. Following Piaget's (1973) idea, Kolb focused on the strict links between learning and knowledge. The key to learning lies in the mutual interaction of the process of the accommodation of concepts or 'schemas' (new concepts with which to better experience the world), and the process of assimilating events and experiences from the world into existing concepts and schemas. Learning results from a balanced tension between these two processes.

In the paragraph that follow, I will describe into more details the Kolb's model of learning, its relevance to the training and clinical supervision setting, as well as some of its limits.

### **2.9.2 Characteristics of Experiential Learning**

According to Kolb (1984), experiential learning occurs as a direct result of the learner's participation in events and so utilises the participant's own experience and their own



reflection about the experience. It is a learner-centred approach, which starts from the premise that people learn best from their own experience (learning-by-doing), and is particularly effective due to its holistic way of addressing the cognitive, emotional and physical aspects of the learner. Later in this chapter I will illustrate an example of the application of Kolb's theory.

Learning is the result of an experiential circle: knowledge is acquired through experience and tested out in everyday life. Learning results from confrontation and the resolution of conflicts. Two aspects can be seen as especially noteworthy: the use of concrete here and now experience, to test ideas, and the use of feedback to change practice (Kolb 1984 pp.21-22). As illustrated above, Kolb (1984) integrated these two aspects into Dewey's (1938) work to emphasise the developmental nature of learning and into Piaget's (1973) to recognise the role of cognitive development.

In order to illustrate his model, Kolb (1984) presented it in the form of an experiential learning cycle, based on four key elements: 'concrete experience', 'observation and reflection', 'forming abstract concepts' and 'planning for new situations'. Kolb argued that the learning cycle can begin at any of these four points, although the one mentioned above is the most likely to happen. This very well known model can be applied to many learning situations in every-day life, including training and education in general. For example, the experiential way of learning involves the application of the information received from the trainer to the experiences of the trainee with clients. By so doing, the learner transforms both the information and the experience into knowledge of some new or familiar subject or phenomenon. More specifically, in the concrete experience phase,

trainees are fully involved in an experience, as for example working with their clients. In the first phase, the educator involves the learners in a concrete experience. The experience could be a role-play, a live or video demonstration, a case study, or a testimonial. Then during the reflective observation phase, they step back and reflect on their experience (the work they have done with clients). The learners are then asked to review the experience from many perspectives. They ask themselves questions that might help in the reflection of what happened. This second phase is referred to as reflective observation. During the abstract conceptualisation phase, they combine their observations and reflections and convert them into sound theories. During the third phase of abstract conceptualisation, the learners develop theories and look at patterns. The trainer encourages the learners to find meanings for what they have observed, why it is significant, and which conclusion can be drawn. This could happen, for example, through didactic learning in a classroom situation or through supervision sessions. The fourth and final phase of this experiential model is active experimentation. Learners test these theories and use them as bases for new actions. This could be the case with students who go to a placement, or trainees who apply their newly learnt skills with clients (Sugarmann, 1985).

### ***2.9.2.1 Practical Applications of Kolb's Theory***

In an attempt to operationalise Kolb's theory, Milne *et al.* (2002b) investigated the impact of the trainer's behaviour on the learner. They developed an observational instrument that they called Process Evaluation of Teaching and Supervision (PETS), which records the extent to which the different trainers' behaviours impact on the learner's movement around the four elements of the experiential learning cycle:

experience, observation, conceptualisation and experimentation (p.190). They divided Kolb's experimentation category into two elements: 'experiencing', which emphasises 'the emotional accompaniments of action', and 'experimenting', which indicates 'engaging in an action, a behavioural phase' (p.189). In order to monitor the extent to which the different trainer behaviours impact on the learners' movement around the experiential learning cycle, a recording procedure was utilised. This procedure alternated between an initial focus on the trainer, followed by a focus on the learner. From this sequential recording procedure, it emerged that the trainer preferred a didactic approach, and consequently the impact was limited to the learners' cognitions, rather than influencing their feelings and behaviour. This is one example of the use of this instrument; it has also been applied in the CS situation in order to explore the interactions between supervisors and supervisees. It would be interesting to investigate how a more experiential teaching or supervisory approach, aimed at influencing feelings, might impact on the movements around the experiential cycle.

Not all writers agree with Kolb's (1984) theory. The learning cycle approach has been seen as 'normative' and 'prescriptive' (Rogers; 1996, p.111) with critical reflection as not the only way in which adults learn. Rogers argued that, 'learning includes goals, purposes, intentions, choice and decision-making, and it is not at all clear where these elements fit into the learning cycle' (Rogers; 1996, p.108). It is also unclear what the role of the context of learning is. According to Gould (2000) the experiential model of learning needs to incorporate a number of organisational variables. He conducted a series of semi-structured interviews with practitioners, middle and senior managers working in

a national child care agency. He wanted to construct a perspective on processes which supported or obstructed organisational learning. The findings of Gould's study (2000) revealed that different needs have to be developed in order to achieve effective learning. These are listed below, and are

- Team-based activities (co-working, presentations within team meetings etc);
- Effective dissemination of learning and new knowledge between peers and between hierarchical levels;
- The need to develop systems of data storage and retrieval to create an 'organisational memory'; and
- The need to incorporate evaluative enquiry within organisational processes.

The evidence from this study highlighted that the individualistic experiential learning model needs to incorporate some of the processes suggested, including environmental and organisational variables into the study of learning processes.

## **2.10 Factors that Influence Learning**

Training and transfer have been widely investigated, with some authors (for example Warr & Downing, 2000, Hook & Bunce, 2001) suggesting that emotions play an important role in the process, but as yet no one has conducted a systematic study of this aspect. Research on the training context is usually focused on pre-training characteristics, training methods and post-training conditions. I will examine these three main areas below in order to illustrate the literature on training and transfer and discuss those studies that have considered emotions as important variables.

### ***2.10.1.1 Pre-training conditions***

According to Salas and Cannon-Bowers (2001), antecedent training conditions (or pre-training characteristics) are usually categorised as:

1. Trainees characteristics, such as: cognitive ability, motivation, self-efficacy and emotion;
2. Variables that engage the trainee in the learning activity, such as motivation; and
3. Preparation for training, as for example training induction.

For the purposes of this thesis, I will look more carefully at points 1 and 2.

### ***2.10.1.2 Trainees' characteristics***

Some reviewers (e.g. Warr & Downing 2000), have pointed out that research in learning has focused on the acquisition of declarative knowledge, which consists of factual information, for example didactic material, and usually precedes higher order development (Kraiger *et al.* 1993). As illustrated above in the introduction to Kolb's theory (see p.40), cognitive processes are not the only ones responsible for successful learning and it is therefore appropriate to study other strategies. For example, interpersonal processes in learning in a professional setting are probably important: trainees interact with other people (fellow trainees and the trainer) and with a wider environment (colleagues at work). 'Affective' strategies (Weinstan & Mayer, 1986) are also considered to be relevant. These are thought to have an indirect impact on learning, influencing motivation levels and anxiety management.

In a review of the literature on the affective aspects of learning, Boekaerts (1996) summarised the work of Hembree (1988). In a series of laboratory experiments, it was

found that anxiety interferes with the task-relevant information needed for processing capacity in the working memory. According to Boekaerts (1996), this could explain the fact that anxious students make use of inappropriate cognitive strategies for the achievement of successful learning outcomes. Boekaerts also studied how anger can influence the performance of secondary school students. Students may get angry for a variety of reasons, for example if the teacher reprimands them, or when they are not allowed to finish an interesting task. Such situations are likely to increase the level of physiological arousal in most students. He also found that suppressing and controlling anger makes great demands on the individual's processing capacity and may interfere with task performance. The effects of sadness, depression, joy and happiness have not as yet been studied extensively in the classroom situation.

Several laboratory studies have explored the effects of emotion on cognition and the fact that emotions influence human cognition is widely recognised in psychology (Damasio 1994, Ekman & Davidson, 1994). For example, Moore and Oaksford (2002) conducted a study in order to look at how learning is modulated by the emotional state. They studied the long-term effects of emotion on cognition over a 12-day period. The participants consisted of a total of 36 undergraduate psychology students. They were engaged in five similar experiments over a 5-day-period. The first four days of the study ran consecutively, with each participant going through mood induction procedures and then being asked to perform some learning tasks. In the fifth session, which occurred after 12 days, participants performed the learning tasks without the mood induction procedures, so that their retention could be checked. The results suggested that, in general, positive

emotional states lead to better performances and that heightened emotional states enhance the consolidation of long- term memory, while induced negative states lead to slower performance. However, the study seemed to have low ecological validity, as the conclusions cannot be generalised to naturally occurring situations and are restricted to the sample of undergraduate psychology students.

Warr and Downing (2000) criticised the fact that learning procedures have in the main been investigated in laboratory settings. They conducted a cross-sectional study focused on adult/professional learners, and suggested that three types of learning strategies are used when acquiring new material: cognitive, behavioural and self-regulatory.

Cognitive strategies include rehearsal, a mental repetition of the presented information, and the organisation of mental structures that cluster the key elements to be learned and interrelated. Furthermore, amongst the cognitive strategies, they considered the elaboration procedures that are employed to examine implications and make connections between new material and existing knowledge. Behavioural strategies are believed to be interpersonal help-seeking, for example asking for help, and seeking help and information from documents or other forms of written material. Self-regulatory strategies are motivation monitoring and emotion control. In particular, the latter is defined as 'procedures to ward off anxiety and prevent concentration failures caused by the intrusion of anxiety-linked thoughts' (p.313). Warr and Downing (2000) wanted to demonstrate that these different learning strategies vary and are positively associated with effective learning and success in knowledge acquisition tasks. Particularly relevant for the present thesis, is one of the objective of their study, which was assessing the influence of learning

anxiety on each of the three learning procedures mentioned above. Their study sample consisted of 288 adults attending a course in preparation for work as vehicle technicians. Each course involved approximately 12 trainees. Multi-item-scales were used to measure learning ability, motivation, anxiety and load prior to the course. In order to monitor the learning strategies employed by the trainees, a 54-item-questionnaire was administered at the end of the course.

In order to investigate those factors associated with the use of each learning strategy, the authors conducted a regression analysis. They found that less learning occurred for trainees who reported using more rehearsal, interpersonal help-seeking, emotional control and motivational control. A prior measure of learning anxiety was shown to account for the pattern.

Warr and Downing (2000) concluded that anxiety had an influence on learning strategies, with a more positive association between strategies and learning occurring with less anxious trainees. For more anxious individuals, reports of strategies used were especially correlated with poorer learning. Warr and Downing (2000) also commented on the fact that the emotional impact linked to learning tasks seems greater in professionals engaged in qualifying courses, making substantial career decisions and for whom improvements in their job prospects may depend on the success of their training course. Adult learners may be involved in occasional training activities, in contrast to college students who are regularly involved in learning tasks. In this situation, learning can induce 'uncertainty, disorientation and feelings of powerlessness and loss of status identity' (Atkins, 2002, p.60). The trainees may be 'redesigning' (Atkins, 2002, p.60) some of the skills that they



already have and which will play a new role both with clients, and in the organisation where the trainee is working.

In their meta-analysis on training motivation, Colquit *et al.* (2000) concluded that anxiety reduces training motivation, but that there are still many factors that need to be investigated. As Boekarts (1996) argued, the role of other emotions, for example sadness, depression, joy and happiness, has to be investigated in a classroom/training situation and the consequences of both positive and negative emotions should be explored. He argued that, for example emotions provide information about the environment, which is then categorised as ‘problematic’ or ‘unproblematic’ (p.586) and students/trainees adjust their information processing behaviours accordingly. For example, if a trainer generates feelings of anxiety the general training environment might be perceived as threatening and the trainee could behave in a defensive way, (e.g.: he or she might try to please the trainer). It would be interesting to examine which emotions are present in a training situation and what role they play.

#### **2.10.2 Training context and training methods**

According to Salas and Cannon-Bower (2001), there is no single method for delivering training, but these criteria should be followed:

1. Presentation of relevant information and the notions to be learned.
2. Prove that knowledge, skills, and abilities can be acquired.
3. Give opportunities to the trainees to apply the skills that they are learning.
4. Provide feedback during and after practice.

There are different techniques and methodologies that are used to achieve training goals for example team training, simulations, role-playing and lectures. The programmes for MHPs reviewed earlier in this chapter (section 2.5) generally focused on the first two of the above criteria. That is by presenting the information through lectures and workshops and testing the knowledge and skills through assignments such as writing essays and making tape recordings of work with service users and their families.

It is in their own work settings that students on the programme are expected to apply their knowledge and skills, with the support of supervisors (criteria 3 and 4). I shall call this opportunity for the supervisee to reflect on their practice and work with the clients and to receive feedback from a more experienced practitioner 'clinical supervision' (CS) because it happens in a clinical (practice) setting, and also to distinguish it from management supervision.

In this section, I will focus on some relevant issues raised in the research on CS and highlights aspects that need more investigation.

### ***2.10.2.1 Clinical Supervision***

CS is not only a requirement, but is also an essential process for the development of competence in trainee therapists (Milne & James, 2002; Watkins, 1997). It is typically an intensive, interpersonal relationship involving two people, the supervisee and supervisor, where the supervisor is expected to facilitate, through a focused relationship, the development of the supervisee's therapeutic competence (Bernard & Goodyear, 1992).

The literature contains a number of descriptions and definitions of CS. Carroll (1996) described it as ensuring the welfare of the clients, as well as facilitating the development of the supervisee in their clinical work. In order to achieve these aims, CS should perform the function of support, education and evaluation against the norms and standards expected within a profession. (Townend *et al.*, 2002). Gilbert and Evans (2000) described CS as taking place when a less experienced psychotherapist consults more senior and experienced practitioners in the field, in order to learn from their expertise.

According to Townend *et al.* (2002), the many different definitions of CS emphasise different aspects. However, there is a general agreement within the literature that its primary focus is the welfare of the client and that it is a learning process, in terms of knowledge attainment, attitude refinement and skills development. Through CS the supervisee is able to develop him or herself with the help of another (Carroll, 1996; Hawkins & Shohet, 2000; Gilbert & Evans, 2000; Scaife, 2001).

Sellars (2004) summarised the different models that have been developed as a framework to guide the practice of CS. These include Heron's (1990) intervention analysis model, which explores the intervention styles that can be used in supervision. Hawkins and Shohet's (2000) constructed the double matrix model of the supervisory relationship, and Johns's (1993) model of professional supervision addresses the various constituents of the supervisory relationship. According to Sellars (2004), Proctor's (1991) three function interactive model appears to be the most widely accepted. Proctor (1991) identified three functions of CS. The normative functions are concerned with managerial issues and the

maintenance of professional standards; the formative functions are linked with the development of skills, ability and understanding, and the restorative functions seek to create a supervisory relationship in which the supervisees feel valued and understood. This last function is linked to the idea that emotional elements are a relevant aspect of the learning process.

In a small pilot research study, Turner (2000) examined the involvement of line managers in supervision and mentoring in child and family social work. She interviewed a sample (N=20) of social workers, first-line managers, staff development officers and senior managers. From the results it emerged that supervision had managerial, educational and supportive aspects. She outlined some of the difficulties faced when involving managers in supervision (conflict of interest, lack of objectivity and lack of training), but also some potential benefits. In particular, she argued that a more developmental and supportive supervision style would be of greater advantage than a narrow managerial approach.

#### ***2.10.2.2 Psychological and interpersonal aspects of supervision***

A few empirical studies have recognised the importance of the psychological content of the supervisory relationship, such as the emotional and learning elements. The existence of emotions/affect in the supervision process is starting to receive more recognition from researchers (Macdonald, 2002). Saarikoki and Leino-Kilpi (2002) conducted a study that was aimed at describing students' perceptions of the clinical learning environment and CS. The results demonstrated that a positive ward atmosphere and attitude could be created towards students and their learning needs. The analysis indicated that the most important factor in the student's clinical learning was the supervisory relationship. In this

study, the level of satisfaction of the students correlated with the method of supervision. The most satisfied students were those with a successful mentor relationship, which included the following features: 'a tight cooperation between student and supervisor; separate supervision sessions, for example one a week, the supporting content of the relationship involving the elements of equality, mutual interaction, respect and a sense of trust' (p.265). These results are in line with the idea of the multidimensional approach to learning described above, where cognitive abilities are not the only factors responsible for successful learning.

Severissson and Hallberg (1996) conducted a cross-sectional study in order to investigate nurse supervisors' views of their supervisory styles, personal qualities and their leadership role, as well as the development of these styles. The data were collected from a sample of 18 trained nurse supervisors, who took part in an interview and completed a questionnaire. The interviews were analysed according to the hermeneutic methodology and a factor analysis was conducted on the questionnaires. Two specific supervisory styles emerged: the emotional and the cognitive. The first of these was defined as 'creating a relationship and using dialogue with the supervisees, and giving an affective response and sharing the supervisees' feelings of guilt, irritation and failure' (p.155). The cognitive style was more related to the support given to the supervisee to 'understand and reflect' (p.156) on his or her own practice. According to these results, the supervisor interprets his or her role as a facilitator of problem solving processes and of reflection on emotions. However, the authors did not measure which of the two identified styles was more effective and conducted their analysis on a rather small sample. Furthermore, it

would be interesting to include a sample of supervisees, in order to compare the views of the two groups.

Back in 1988, Schwarz had identified the trainer-trainee relationship as an important element in family therapy training. Interestingly, he focused on the trainer's attitudes, and argued that, 'the trainer needs to feel self-confident in his or her level of knowledge, as well as with the trainee'. According to him, this is particularly true when working with a trainee that uses a different theoretical framework. Self-confidence helps the trainer 'to recognize that different people have different styles of learning and welcomes the challenger as much as the true believer for helping him or her to learn how to train' (p.175). However, the evaluative nature of the training context is at the origin of some difficulties, as the 'trainee's self-concept as a clinician is on the line' (p.177), especially in live and video forms of supervision, when the trainee's mistakes cannot be hidden.

It seems there is a need to investigate more systematically the experience of emotions in clinical supervision and how these may influence learning and performance with clients, taking into account the views of both supervisors and supervisees.

### **2.10.3 Post training conditions: learning outcomes and learning evaluation**

As discussed in section 2.5, the lack of implementation of the knowledge and skills acquired through MHP training has been a concern, with authors identifying various barriers to the implementation of training. In this section I will present some theoretical issues linked to learning evaluations and learning outcomes.

Hook and Bunce (2001) distinguished between training evaluation and training effectiveness, suggesting that the first is tailored to check whether trainees have achieved learning outcomes and is more of a managerial concern. While the second aims to establish whether the training outcomes have been achieved by analysing the trainee's characteristics and the organisational factors.

Gagne' (1984) proposed a set of categories of learning outcomes in order to organise human performance, pointing out the multifaceted nature of learning. Together with the classical aspects of learning studied by cognitivists (intellectual skills, verbal information, cognitive strategies, motor skills), he included attitudes and reasoning. According to him, these factors can determine performance. Kraiger *et al.* (1993), in line with this taxonomy, suggested that attitudinal outcomes, together with motivational outcomes, are key elements for effective learning outcomes. They attempted to develop a new classification scheme for evaluating learning outcomes. They proposed a cognitive skill-based and affective model as recommended potential evaluation procedures. Drawing on Gagne's work, they defined affectively based measures of training as a class of variables including attitudes, motivation and relevant goals. These factors are considered as indicators of learning: if a trainee's values have undergone a change following training, then learning has happened. Affective outcomes that may follow training are, for instance, creative individualism, organisational commitment, recognition of what is important to learn and group norms. Motivation has been considered as a second type of affective outcome in training and two dispositional orientations have been identified: mastery orientation (concern to increase one's competence) and performance orientation (intention to do well and gain positive evaluation by others). Self-efficacy is another

important factor that they identified as being relevant to learning. Self-efficacy is defined as one's perceived performance capabilities for a specific activity (Bandura 1983). The work of Kraiger *et al.* (1993) is of particular interest, as they tried to extend the well-known Kirkpatrick model (1967), which comprises four levels of evaluation that correspond to different aspects of training. The first level is known as 'reaction' (learner satisfaction and general impressions of the training). The second measures the 'learning' that has occurred during training, while the third, 'behaviour', is related to the transfer of what has been learnt to the workplace. The final level, 'results', is concerned with the improvements that have taken place in the workplace, for example in the quality of care and of service users' lives.

Hook and Bunce (2001) used the label 'session process variables' (p.457) to refer to Kirkpatrick's 'reaction' level. They distinguished between 'session impacts', for example the consequences of training on the job, and 'affective reactions' (2002, p.457) which relate to the feelings experienced during the training session, for example warmth, empathy and enjoyment. In particular, they hypothesised that warmth and empathy were positively associated with immediate learning. In order to test this hypothesis, they developed an ad-hoc questionnaire to measure the two kinds of session process variables (session impacts and affective reactions), and a 15-item learning test was administered to measure declarative knowledge. Both measures were administered to 57 trainees attending a training course on the introduction of new computer systems. The length of the course was not specified. It was found that, both session impact and affective reaction play an important role in training outcomes. In particular, measures of warmth



were associated with positive learning outcomes, while empathy was negatively associated with learning. Drawing on some theories from the psychotherapy literature, Hook and Bunce (2001) explained this result, which contradicted the predictions of the study, with the fact that the trainees may not have felt challenged enough. However, this research has highlighted some important aspects that contribute to the success or otherwise of a training programme, but further investigation is needed.

### **2.11 Conclusions**

The government policies that I have summarised in this chapter outlined the importance of the implementation of successful training for MHPs. However, there is evidence that training outcomes (as for example training for PSI) are not always achieved. Furthermore, factors that influence training effectiveness (in contrast with training outcomes, see for example page 54) are not always been explored in depth. If, as suggested by this literature review, learning is a holistic process, then psychological factors, which include emotions, should be taken into consideration.

From this literature review, I conclude that emotions are an important part of the training, CS and transfer processes, and more research needs to be done to clarify their role. In the next chapter, I will illustrate some relevant theories of emotions and how these can be applied to this field of study. The conclusion of this literature review will lead to the research questions of this thesis.

### 3 APPLICATION OF THEORIES ON EMOTIONS TO TRAINING AND TRANSFER

In the previous chapter I reviewed the process of training in PSIs and the transfer of knowledge and skills to practice in mental health services. I have also presented general definitions of training, learning and transfer in mental health and considered how they can be related to emotions. However, I did not explain what emotions are. In this chapter I will describe some relevant theories of emotions and consider how these can be related to current research on the role of emotions in training and in the transfer of learning to the workplace. I will also introduce the concept of coping and explain how it is related to emotions. Finally, I will present the objective and hypotheses of the study.

#### 3.1 The Study of Emotions in Psychology

Plutick (1994) described the development of the theories of emotion. He classified them as motivational, cognitive, psychoanalytic and evolutionary. These theories will be reviewed later in this chapter, but I will define some of the terms used.

##### 3.1.1 Some definitions

There are a number of different models of emotions that could help to understand the process of learning and of transfer.

For example, there is general agreement that the experience of emotions and mood can be constructed within the wider terminology of 'affective states', which comprise moods, emotions or feelings (Lorr, 1984, Faith & Thayer, 2001). Here, 'affective states' are used

as an umbrella term to encompass these phenomena. Although some researchers (e.g. Forgas 1992) have claimed that the distinctions between mood and emotions are elusive, a more popular idea is that the distinction lies in their duration. Thus, an emotion is considered to be brief and event-specific whereas a mood is broader and lasts longer (Ekman & Davidson, 1994). Other similar definitions of emotions include that of Kokken and Pulkkinen (2001), who asserted that emotions are relative, intense and brief feelings, and are event specific. However, Ekman and Davidson (1994) argued that this criterion is purely descriptive and 'it is likely that instances of short-lived mood and longer-lived emotion can be found' (p.52), and a functional explanation would help to understand the differences between these two constructs. Thus, Fridja (2000) argued that the primary function of emotion is to regulate action, because emotions often occur when an adaptive action is necessary. However, Ekman and Davidson (1994) reported that the primary function of mood is to modulate cognition: 'Mood serves as a primary mechanism for altering information-processing priorities and for shifting modes of information processing' (p.52). For example, trainees in a low mood may have increased accessibility to past unsuccessful experiences in training, such as the failure of academic assignments. Similarly, if trainees are experiencing difficulties in transferring learning to the workplace, they may be recalling ineffective interventions with clients. In both cases this may result in a reduction of their learning motivation, and in how often they practice new methods. In other words, moods create the affective environment that modulates our thoughts and influences the beginning of a certain emotion. Another relevant difference between mood and emotion is the nature of the antecedent event that elicited them. Emotions are triggered by events that are perceived as occurring quickly and without

warning, whereas mood may occur following an event that is perceived as happening over a slower period of time. For example, when a trainee is suddenly challenged by a tutor he or she may experience emotions of discomfort as well as physiological reactions, such as becoming red in the face and having sweating palms. Mood can be induced by a series of both negative and positive experiences. For example, a previous experience of successful role-play during training may reduce the anxiety of role-playing in a classroom situation. Finally, Ekman and Davidson (1994) concluded that 'emotions can lead to particular moods and mood can alter the probability that emotions will be triggered' (p.53), and recognised the necessity of gathering systematic data to explore the interaction between mood and emotions. However, this view has been disputed, with some researchers believing that the experience of emotions is not inherent in the situation itself, but in the evaluation of the situation (Boeckaerts, 1996). Hence, it is the trainee that perceives a training situation as challenging, or satisfying, rather than the situation itself being challenging or satisfying. This concept has been widely described by appraisal theories, which I will illustrate later in this chapter.

There is also a debate on the function that emotions serve. According to Moore and Isen (1990), the three main functions of emotions are:

1. Preparing for action. Emotions are stimuli that aid the development of effective responses to various situations. For example, anxiety makes people feel more alert, thus enhancing levels of concentration.

2. Shaping our future behaviour. Emotions serve to promote the learning of information that will assist us in making appropriate responses in the future. For instance, people will try to replicate a behaviour that has made them feel happy.
3. Helping us to regulate social interaction. Emotions are communicated through verbal or non-verbal behaviour, which can act as signals to an observer. Becoming red in the face because of feeling embarrassed, for example by being made to be the centre of attention, might communicate discomfort.

In the review of various research approaches that follows, I will look at these functions in more detail.

### **3.2 The Different Traditions**

In the paragraphs that follow, I will introduce the main theoretical approaches to understanding emotions. I will briefly introduce each approach and then comment on his relevance to the contribution of the study of learning in the mental health setting.

#### **3.2.1 The evolutionary tradition**

According evolutionary theorists, emotions have an adaptational role, and increase the chances of individual survival through appropriate reactions to emergencies.

Charles Darwin (1809-1882) was the founder of the evolutionary tradition. In 1872 he published his famous book, *The Expression of Emotions in Man and Animals*, which has

deeply influenced modern thinking on emotion. Darwin concentrated his attention on expressive behaviour, such as facial expression, relying on data collected through naturalistic observation. He aimed to demonstrate the basic continuity of emotional expressions from lower animals to humans, arguing that emotions play an adaptive, communicative function.

These concepts have been developed by modern evolutionary theorists. Specifically, Fridja (2000) summarised the main functions of emotions as follows:

1. Emotional expressions play a functional role, such as communicating from one animal to another what is likely to happen next. The expression of emotion orientates a response and is informative. For example, in a training situation lecturers realising that the trainees look anxious and confused will rephrase what they are saying, using helpful examples or more accessible language by reducing jargon terms.
2. Emotions deal with the adaptational difficulties, identifying, through appraisal mechanisms, 'edonic or concern-relevant events' (Fridja, 2000, p.215), and resulting in different behaviours each time, allowing flexible adaptation to the situation. For instance, events that are perceived as threatening, as where the supervisee perceives CS as stressful, may trigger defence mechanisms.
3. Emotions regulate and constitute interpersonal relationships and social harmony. For example, shame enforces behaviours in agreement with social habits, (e.g. the trainer

and trainees will switch their mobiles off, in order not to receive phone-calls during teaching sessions, as this is seen as inappropriate and a cause of embarrassment).

In conclusion, Cosmides and Toby (as cited in Fridja 2000) argued that these concepts are now widely accepted in ethology and evolutionary perspectives. According to Fridja (2000), the main contribution of the evolutionary tradition is that a functional, adaptive and useful view of emotions has become widely accepted.

#### **3.2.2 The biological tradition**

The biological tradition emphasises the subjective aspects of emotion and the way in which the body's physiology supplies the feedback necessary for the perception of an emotional state.

William James (1842-1910) is the father of the biological approach. He proposed that bodily changes directly follow a perception of an existing event and that the feeling of these bodily changes is an emotion. He argued that emotions are consequences rather than antecedents of physiological changes brought about by some external stimulus. A critic of James' theory was W.B. Cannon who, in 1929, undertook some experimental studies on animals and demonstrated that lack of feedback from physical changes had no effect on emotional expression. Cannon presented an alternative theory, suggesting that neurological stimulation brought about by an external event, for example a dangerous situation, simultaneously produces an emotional experience (fear) and a series of bodily changes (erection of tail hairs, sweating, dilatation of pupils).

Research on the physiology of emotions has enormously developed during the last few decades. The main contribution of the biological approach is the idea that emotions are also physiological processes, with biological, neurological and neuropsychological mechanisms implied (Cacioppo & Gardner, 1999). Recent applications of this theory include work on biofeedback. Biofeedback is a treatment technique in which people are trained to improve their health by using signals from their own bodies. Feedback of physical responses such as skin temperature and muscle tension provides information to help patients recognise a relaxed state. The feedback signal may also act as a kind of reward for reducing tension. It can be used to help tense and anxious people learn to relax. Specialists in many different fields use biofeedback to help their patients cope with pain. It is aimed at changing habitual reactions to stress that can cause pain or disease (Greeno *et al.* 1996).

#### **3.2.3 The psychodynamic tradition**

The psychodynamic tradition suggests that there are unconscious mechanisms involved in the experience of emotions. As Putlick (1994) remarked, no formal psychoanalytic theory of emotion has been formulated, although there are theories of anxiety that have been highly influential, such as that illustrated by Freud in *Inhibitions, Symptoms and Anxiety*, published in 1926.

Further developments of Freud's theories, including the anxiety defence model have illustrated how feelings, thoughts and behaviours arise in response to the perception of psychic danger, in order to avoid anxiety-linked and harmful thoughts (A. Freud, 1946).



Another popular idea is that of the isolation of affect, in which an emotion is detached from an idea and transformed into an unconscious thought, leaving the original idea with no emotional valence.

More recently, Mayer *et al.* (1991) developed a model of emotion management that has much in common with the idea of the defence mechanism. In order to investigate mood management experiences, they conducted a series of studies using a sample of college students. Mayer *et al.* (1991) used a mood-stated scale in which participants were asked to record both their emotions and their thoughts that related to mood management. From the results obtained, they noticed that suppression and denial-experiences, increased as the mood become more negative. They concluded that emotion-management experiences had much in common with the idea of defence mechanisms (Freud, 1946), and with styles of coping (Lazarus & Folkman, 1984), which I will introduce at the end of this chapter.

Nichol (1997) investigated the role of emotional pain in learning and personal change through group psychotherapy. He suggested that the need to go through pain during group analysis has been taken for granted to such an extent that very little has actually been written about it. He suggested that there is a need to develop a theory of emotions in learning that both group therapists and other professional groups could use. He went on to suggest that if emotional pain in learning was seen as normal then teaching strategies derived from a model could be developed to work with the emotions involved in learning in a constructive way.

Paterson and Groening (1996) presented some arguments to support the idea of counter-transference in clinical teaching. Counter-transference is defined as 'the analyst's emotional reactions to the patient's transference, influenced by the analyst's unconscious needs and conflicts' (Colman, 2001, p.173). Paterson and Groening (1996) recognised that there are similarities between teaching and psychotherapy, such as dialogue, relationship and acknowledgment of the uniqueness of the person. They identified and provided examples of two different types of counter-transference: student-induced and teacher-induced counter-transference. According to Paterson and Groening (1996) student-induced counter-transference occurs where, for instance, a student is dependent on the teacher, thus arousing the teacher's frustration with the students' dependency. An example of teacher-induced counter-transference would arise where 'a teacher who believes that women should be submissive is overly critical of a female student who openly confronts a male physician' (1996, p.1122). Marshall and Marshall (as cited in Paterson & Groening, 1996) identified a number of antecedents of induced counter-transference, such as needs that are not being met. These antecedents also include 're-enactment of previous incidents that are associated with specific feelings and responses, and the sexual, gender, social, and professional role identity' (1996, p.1122). Furthermore, Paterson and Groening (1996) highlighted the negative consequences that counter-transference might have on students 'it has been demonstrated to interfere with the clinical teacher's ability to know students as individuals [...] and contrast students' ability to learn and perform in the clinical area' (1996, p.1125).

The idea of counter-transference in the teaching situation suggests that teachers should recognise and contain strong feelings (e.g. anger, shame, guilt) as suggested by Mishma and Rasmussen (2001). Furthermore, the concept of counter-transference in teaching is very relevant indeed to the study of emotions in training and transfer. However, it limits the role of emotions to the relationship between the trainer and the trainees, leaving out all the other variables that are present in a learning context.

#### 3.2.4 **The behaviourist tradition**

Behaviourist theories emphasise observable behaviour and focus, in the main, on learning processes.

B.F. Skinner's theory is usually taken to be the most pervasive but not the only form of behaviourism. This theory, developed in the 1960s, is based upon the idea that changes in behaviour are the result of an individual's response to events (stimuli) that occur in the environment. When a particular stimulus-response (S-R) pattern is reinforced (rewarded), the individual is conditioned to respond. A reinforcer is anything that strengthens the desired response. It could be verbal praise, a good grade or a feeling of increased accomplishment or satisfaction. The theory also covers negative reinforcement (punishment), which results in the reduction of undesired responses.

Emotions are considered to be another form of learned behaviour. Observable emotional behaviour, such as sweating, rapid heart-beat, or blushing, can become associated with a stimulus through operant conditioning. Over time, merely seeing the stimulus may be adequate to produce a certain behaviour or feeling (Plutchik, 1994). For instance, a

trainee who has experienced failure when giving a presentation to the class, might be negatively reinforced by that failure, and then experience negative sensations every time the trainer suggests the possibility of class presentations.

The implications of this theory can be used for the development of programmed instruction in the following ways (Markle, 1969; Skinner, 1968):

- Practice should take the form of question (stimulus)-answer (response) frames which expose the student to the subject in gradual steps.
- Ensuring the learner makes a response for every frame and also receives immediate feedback.
- Arranging the difficulty of the questions so the response is always correct and hence there is positive reinforcement.
- Ensuring that good performance in the lesson is paired with secondary reinforcers such as verbal praise, rewards (prizes) and good grades.

Operant conditioning has been widely applied in clinical settings, in the form of behaviour modification, as well as in teaching, as in classroom management, and in instructional development through programmed instruction.

#### **3.2.5 The cognitive tradition**

According to Cacioppo and Gardner (1999), during the previous twenty years research on emotions has influenced all aspects of cognition and behaviour, including perception, memory, subjective well-being, decision-making and interpersonal relationships. The

physiological aspect of emotions has also been thoroughly investigated, thus improving psychological theories.

Research concerning cognitive appraisal is a vigorous area of research on emotions, where the appraisal of a stimulus or an 'antecedent,' (Cacioppo & Gardner, 1999, p.197) is related to the environmental conditions and the personal goals, beliefs and adaptational resources of the individual. Fridja (2000) has remarked that 'by including cognitive variables among emotions antecedents, appraisal theories substitute the notions of situation for that of stimuli, in describing emotions antecedents [...]'. Recognition that situations rather than stimuli elicit emotions explains that given events may have multiple emotional meanings (Fridja, 2000, p.214). For example, trainees that prefer a less experiential way of teaching (see Kolb in section 2.9.2), and are in favour of a more didactic teaching style, may perceive a challenging trainer as threatening.

Lazarus has elaborated one of the most influential theories of emotions and suggested that the appraisal of the situation influences the emotional response. This concept has been widely studied in clinical psychology and has been taken up in cognitive behavioural therapy (CBT), especially when treating stress-related problems (Fridja 2000). CBT is based on the scientific fact that our thoughts, rather than external factors like people, situations and events, cause our feelings and behaviours. The benefit of this fact is that we can change the way we think to feel / act better even if the situation does not change.

### **3.3 The Lazarus Cognitive-Motivational-Relational Model of Emotion**

Lazarus (2000) defined emotions as 'psychophysiological reactions to ongoing relationships with the environment, most often interpersonal or social' (p.230). Furthermore, he argued that a definition of emotion should also include the causal cognitive-motivational-relational variables and processes involved in arousing and sustaining an emotion, because they are part of the phenomenon itself and help to understand it.

The relational aspect refers to the fact that emotions are connected with person-environment relationships, which involve either harm or benefit. In particular, Lazarus (1991) pointed out that emotion and stress are generated by personal environment characteristics that change over time and situations. For example, in the context of the present study, relationships with managers and peers and with fellow trainees and trainers, levels of social support and climate factors all fall into this category.

Emotional encounters often share a common 'relational meaning' (Lazarus, 1991, p.820), such as a particular harm, threat, challenge or benefit and what might be done to cope with it. Although there are individual differences in emotional reactions even under similar environmental conditions, for instance not all trainees report that performing role-playing exercises generates anxiety, each emotion involves a distinctive 'core relational theme' (Lazarus, 1991, p.820). A core relational theme is a universal way of describing the essence of the person-environment for a particular emotion.

I will summarise the main core relational theme as described by Lazarus (2000) later in this chapter (in section 3.3.3).

The motivational aspect of the model assumes that emotions are a reaction to the status of our goals in everyday encounters and in our lives overall. In other words, motivation helps to understand why a particular interaction is relevant to the individual and a possible source of harm or benefit. It is considered to be a dispositional trait, a personal characteristic, as well as a being transactional in nature. For instance, a highly motivated MHP might not find a suitable client (environment), for the purposes of transferring his or her newly acquired PSI skills, and so feel frustrated.

In this model, the cognitive aspect refers to the individual's appraisal of the significance of the encounter, and knowledge of the situation. Knowledge is believed to be impersonal and consists of generalised beliefs, while appraisal is a person's evaluation. For example, fatigue and mental workload may be transformed into emotional distress or satisfaction as a result of the individual's appraisal. Thus, an MHP engaged in a training course may find it necessary to do extra work for assignments and then go on to experience some burn- out and feelings of distress because of the long hours spent working. However, when a trainee successfully implements a newly learned intervention with a client, the situation could be perceived (appraised) as positive and beneficial.

I will now describe the different aspects of the Lazarus model in more details.

#### 3.3.1 **Appraisal**

The emotions experienced in an adaptational encounter depend upon an appraisal of the significance of what is happening to the individual's well-being; appraisal is a central aspect of Lazarus's theory. It provides the cognitive-relational-motivational key to our emotions and shapes the way we cope with them. It refers to a decision-making process that evaluates the consequences of each person- environment interaction and every event in our lives is considered in light of its relevance to our well-being. Socio-cultural variables and individual history heavily influence appraisal mechanisms. Furthermore, 'Appraisals and the meaning generated from them are always relational because they must simultaneously take into account personal factors and environment demands, constraints and opportunities' (Lazarus 2000, p.233).

Lazarus identified two levels of appraisal. Primary appraisal concerns the relevance of the interaction to the individual's goal, the extent to which the situation is compatible with the goal; i.e. appraisal facilitates the achievement of the goal according to the extent of personal commitment and well-being. Basically, it asks the question 'is this encounter stressful?' (Dewe, 1992, p.7). Secondary appraisal relates to the options for coping and what can be done; three main decisions are implied. The first is 'blame or credit'; acknowledgment of blame or credit will depend on whether there is an attribution of responsibility for the harm, threat or benefit, and the extent to which people are in control of their damaging or beneficial actions. For instance, blame for failure in a training course might be attributed to the lack of teaching skills on the part of the trainer, thus generating anger. On the other hand, trainees may see themselves as the cause of the



failure, thus generating shame, or a sense of guilt. The second decision related to secondary appraisal is linked to coping potential, which has to do with how and whether we improve the person-environment relationship (coping will be discussed more extensively in section 3.4.5). Thirdly, future expectations relate to predictions of future events, whether things will work out positively or will get worse.

### **3.3.2 A discrete approach to emotions**

Lazarus also used a discrete approach, describing emotions on the basis of their qualitative content and considering each emotion as varying along a dimension of intensity. According to Lazarus (1991), this means that grouping positive and negative emotions could be misleading because it overlooks the extent to which each individual emotion is distinctive with respect to its antecedents, subjective experience and outcomes. He preferred to classify emotions into four categories:

1. Emotions resulting from harm, losses and threat. These include anger, anxiety, fear, guilt, shame, sadness, envy, jealousy and disgust. These are also referred to as negative emotions because the cognitive-motivational-relational process involved in their creation is based upon 'discomfort' (1991, p.827).
2. Emotions resulting from benefit. These are defined as 'attaining a goal or subjectively reasonable progress toward it'. These include: happiness and joy, pride, gratitude and love (companion or romantic) and are generated by cognitive-motivational-relational processes based on 'comfort' (1991, p.827).

3. Borderline cases, such as hope, contentment, relief, compassion and aesthetic emotions. For example, Lazarus argued that empathy is 'a capacity and a process rather than an emotional state' (1991, p.827).
4. Non-emotions, which Lazarus (1991) regarded as mediators of appraisal, from which other emotions derive. He divided non-emotions into a number of subcategories:
  - a. Complex states, for example grief and depression;
  - b. Ambiguous positive states, for example challenge, confidence and determination;
  - c. Ambiguous negative states, for example frustration, disappointment, and meaninglessness;
  - d. Mental confusion, for example bewilderment;
  - e. Contentless excitement or arousal, for example upset, distress, nervousness, tension and agitation; and
  - f. Pre-emotions, for example interest, curiosity, anticipation, alertness, surprise, and amazement.

However, it is important to say that this classification is purely descriptive; it is more sensible to talk about core relational meanings, which I will introduce below.

### **3.3.3 The relational meaning of emotions**

Lazarus (1991) argued that each emotion has its own core relational theme, which is a way of describing the person-environment relationship for a particular emotion. He also used the expression 'relational meaning' (Lazarus 1991, 2000) to highlight the process of appraising the personal significance of encounters with other people and the environment.

However, there is a distinctive meaning for each emotion. The core relational meaning for each emotion, in turn, as described by Lazarus (2000) is presented below. In addition, the core relational themes are reported with some examples of how and when a certain emotion may occur in a training, supervision and transfer to work setting.

#### **3.3.3.1 *Anger***

Anger is ‘a demeaning offence against me and mine’ (Lazarus & Cohen-Charash, 2001, p.54)

The provocation to anger is usually an injury to one’s identity. Anger originates in the preservation and enhancement of the individual’s social identity; the presence of anger indicates that the action of another person or agency has been appraised as humiliating, as a demeaning offence. With respect to the training and transfer setting, an important interpersonal situation that may cause anger might be the unwise behaviour of the trainer or supervisor. A trainer might show a lack of concern regarding the progress of the trainees, or a supervisor might ignore a request for help from a supervisee. Some occupational psychology literature (e.g. Pilluta & Murnighan, 1996) argued that anger is a primary response to perceived unfairness, and that this perception is associated with negative relationships with colleagues or managers, depending on who is provoking the anger.

#### **3.3.3.2 *Anxiety***

Lazarus (1991) argued that the core relational theme of anxiety is ‘facing an uncertain threat, which has existential implications, that is, centred on the meanings and sense of identity the individual has constructed’ (p.829). However, anxiety can also be thought of in a positive light. For example, when facing an opportunity this kind of anxiety has been

referred to challenge (Lazarus & Folkman, 1984). Challenge is considered beneficial, the opposite to anxiety, which is constricting and can impair performance. For example, the possibility of promotion for a trainee completing a particular course can be considered as a challenge.

An example of a possible source of anxiety is being evaluated. The threat of being judged negatively may make a person feel inadequate. This 'evaluative threat' (Lazarus 2000) can occur in various relational situations, for instance, having to perform in front of an audience, or having to discuss a difficult clinical case with a supervisor. Lazarus (2000) also distinguishes 'non evaluative threats', which might for example include trainees' uncertainty regarding their role at work after a professional training course.

#### ***3.3.3.3 Guilt and Shame***

Lazarus (2000) argued that guilt has both a negative and positive valence. The negatively valenced core relational theme for guilt is 'having transgressed a moral imperative', while the positive one is 'the self-righteous feeling of having our moral lapse remedied by performing acts of contrition' (p.243). However, shame is always negatively toned; its core relational theme is 'having failed to live up an ego ideal' (p.243).

For example, when working in a group situation during a training session, or when attending a group supervision session, a trainee or a supervisee that does not contribute adequately will probably experience feelings of guilt and shame.

Applied to the training and supervision setting, guilt may ensue when a client seems not to have benefited from the sessions; or trainees or supervisees feel shame when they fail to implement a particular skill with a client.

#### ***3.3.3.4 Envy and jealousy***

According to Lazarus and Cohen-Charash (2001), there are similarities between these two emotions. Envy is a 'two person emotional state, in which one person hungers for what another person has, and feels unjustly deprived of it; jealousy is a three-person emotion. One person resents another, who is a rival, for an expected or hoped-for reward from a third person' (2001, p.64).

Within the training setting, promotion of a fellow trainee after training, or a colleagues' better results when applying the new skills with clients may generate envy or jealousy. However, envy happens when the fellow trainee gains, while jealousy happens when the colleague gains or threatens to gain at the expense of the individual. Some positive aspects can be found in jealousy, as loss or threats can be seen as a challenge to improve performance.

#### ***3.3.3.5 Hope***

Hope is considered to play an important role in the maintenance of feelings of well-being, especially under adverse circumstances. Its core relational theme is 'to fear the worst but yearn for better' (Lazarus & Cohen-Charash, 2001 p.65). It also seems to depend on the belief that the desired improvement is possible either through personal effort or through external factors, which are not under the individual's control, for example luck, fate or God.

In a training and transfer situation, trainees and supervisees may experience emotions of hope when working with their clients, trying to improve the quality of their lives. Furthermore, hope is also very important when facing failure, for instance when a trainee is highly committed to successfully implementing new skills with clients. 'If one can preserve hope, even following discouraging performances, there is more likelihood that full utilisation of resources can be restored' (Lazarus, 2000, p.267).

#### **3.3.3.6 *Happiness/Joy***

Lazarus (2000) defined the core relational theme of happiness as 'making reasonable progress towards the realisation of a goal' (p.234). However, getting what we want produces only short-term gratification. Even when a desired outcome is reached, the success soon fades into the past and new goals are set; a trainee that has finished a professional course and holds a new qualification may, for example, then set a new goal and look for a suitable job.

#### **3.3.3.7 *Pride***

According to Lazarus (2000), the core relational theme of this emotion is 'taking credit for a valued object or achievement, either one's own or that of another person or group with whom one identifies' (p.235). However, pride differs from happiness because its main function is to protect the individual's self-esteem. Pride can be provoked, for example, when a clinician successfully implements new skills, thus being beneficial for the client.

#### **3.3.3.8 *Compassion***

The core relational theme of compassion is 'being moved by another person's suffering and wanting to help'. Although compassion is closely linked to the concept of empathy,

Lazarus (1991) made clear the difference between the two. Compassion is an emotional state, while empathy is a process and a capacity. In support of this, he argued that empathy cannot be considered as a single emotion, because its characteristics depend on other people's feelings.

This emotion can frequently be seen in MHPs, who are constantly dealing with people that are suffering.

#### **3.3.3.9 Love**

Love's core relational theme is 'to desire to participate in affection, usually but not necessarily reciprocated' (Lazarus & Cohen-Charash, 2001, p.77). According to Lazarus and Cohen-Charash (2001) love has different variants, for example romantic love, parental love and love in the family setting, and some of these may interfere with a working setting. Sometimes love in the family setting may conflict with work commitments, and vice versa. For example, because of the long hours worked by many mental health clinicians, the constraints on their time may give rise to conflicts between their work and family commitments.

#### **3.3.3.10 Relief**

Relief occurs in everyday life after a period of anxiety, and is defined as 'a distressing goal-incongruent condition that has changed for the better' (Lazarus & Cohen-Charash, 2001, p.54). In training and transfer, relief could have a desirable effect on performance because a state of danger and worry is no longer warranted. This may result in the individual feeling more relaxed and comfortable. However, Lazarus and Cohen-Charash, (2001) argued that there is a potential danger in becoming too relaxed. For example,

trainees might undervalue the time required to do their course work and miss important deadlines.

#### 3.3.4 The relationship between stress and emotions

In general, stress has remained a largely one-dimensional concept: stress specifies degrees of external pressure or disturbed reaction. Lazarus and Folkman (1984) defined stress as 'a relationship between the person and the environment, that is appraised by the person as taxing his or her resources and endangering his or her well being' (1984, p.24). They differentiated between two types of psychological stress. One being 'threat' (1984, p.24) which can lead to performance impairment, for example poor levels of learning and transfer. The other, 'challenge', (1984, p.24) is associated with performance facilitation, for example good levels of learning and subsequent transfer. However, Lazarus (2000) subsequently took the position that stress and emotion should be treated as a single field. He argued that 'emotion encompasses all the important phenomena of stress' (2000, p.231) and stress generates emotional consequences. An awareness of the core relational themes of the emotions will help to understand what the person is experiencing when in a stressful condition.

For this reason, stress and emotion should be regarded as a single topic. For example, working to meet a deadline might be considered a stressful event by a trainee and at the same time be experienced as an anxious-related experience. Furthermore, stress can occur with both positive and negative emotions. Finally, both concepts overlap and can be explained by the cognitive-motivational-relational rule model illustrated above.



The next step towards Lazarus theory is the concept of coping, which I will present in the sections below.

### **3.3.5 The relationship between coping and emotion**

When thinking about emotion, the role of coping is often overlooked. However, according to Lazarus's (1991) model, it plays a central role throughout an emotional encounter (Lazarus, 2000). He argued that

‘coping shapes emotions in one of two ways. Problem focused coping often involves planful actions designed to change the actual person-environment relationship by directly acting on the environment or on oneself. Emotion-focused coping alters only what is in the mind in one of two ways, either by attention deployment, for example avoidance, or by changing the meaning of the relationship, for example by denial or distancing, in which the distressing emotion associated with the harm or threat is made moot. For this reason I have sometimes used the phrase cognitive coping as a synonym’ (p.830).

#### **3.3.5.1 *Coping strategies and behavioural outcomes***

Zeidner and Saklofske (1996) summarised the research on the use of different coping strategies. According to them, emotion focused coping may help in maintaining emotional balance, while problem focused coping is more effective in managing problematic situations. The research evidence on the adaptability of emotion focused coping is mixed. On the one hand, avoidance coping strategies, for example distraction, work against people. On the other hand, Zeidner and Saklofske (1996) argued that cognitive avoidance may be effective in coping with short term stressors. For example,

using distraction as a coping strategy may be effective when supervisees are having their CS session in a noisy room. Emotional coping strategies might also be useful because they give the person a psychological break from the pressures of the stressful situation (Carver *et al.*, 1989). Moos (1997) preferred to classify coping strategies as 'adaptive' (situation redefinition, direct action, seeking social support and religion) and 'maladaptive' (distraction, catharsis, acceptance and relaxation). However, while some research supports the relationship between some kind of coping and well-being (Aspinwall & Taylor 1992), the evidence is still weak.

According to Lazarus (1991, 2000) and to the main cognitivist theories, coping strategies should not be prejudged as adaptive or maladaptive. Rather, the concern must be for whom and under which circumstances a particular coping strategy has adaptive consequences. Because coping is a process rooted in a particular context, coping responses may vary across context and change over time.

Parkes (1990) provided evidence supporting the theory that different coping strategies differentially affect emotions. In a research he conducted, specific coping styles led to certain outcomes, indicating that work-related stress was mediated by coping styles. In particular, Parkes (1990) argued that a combination of coping strategies, such as suppression and direct coping, is more likely to reduce stress in stressful situations than one of the forms alone, emphasising the importance of using flexible coping strategies.

Taylor (1986) suggested eight criteria to evaluate coping effectiveness:

1. Resolution of conflicts or stressful situations. Coping with a certain problematic event should remove or alleviate the stressful situation.
2. Reduction of physiological and biochemical reactions. Coping strategies are considered to be successful if they reduce the arousal and its indicators, such as heart rate, blood pressure and respiration.
3. Reduction of psychological distress. Coping helps to control emotional distress and anxiety levels.
4. Normative social functioning. Effective coping implies socially accepted behaviour, for example attending CS sessions on time.
5. Return to present activities. People that have used effective coping strategies will return to their routine activities after a stressful event. However, substantial life changes after a particular stressful event may be a sign of effective coping.
6. Well-being of self and others affected by the situation. This involves the well-being of the person involved and of the people close to the person (spouse, children, colleagues, friends, parents).
7. Maintaining positive self-esteem. Positive self-esteem is an indicator of good adjustment.
8. Perceived effectiveness. This implies that the person who has used a certain coping strategy recognises that the strategy was effective.

However, these are not universal criteria for evaluating the effectiveness of coping. This can depend upon a specific encounter with the environment and is always context specific. As Zeidner and Saklofske (1996) stated

‘the coping response might be judged successful relative to one outcome criteria and not to another. Indeed the resolution of one coping task might even come at the expense of another (e.g., working long hours might be beneficial for both financial and professional success, but contributing to marriage breakdown)’ (p. 509).

Lazarus further pointed out that successful coping strategies will elicit positive emotions and a sense of mastery, whereas unsuccessful coping leads to a sense of strain or distress (Lazarus, 1991). However, the key element of coping is appraisal and ‘changes in the actual person-environment relationship change the way it is appraised’ (1991, p.830).

To conclude, Lazarus (1991) emphasised the fact that coping is closely connected to motivational processes. For example, in looking at the any of the possible emotional encounters between supervisor and supervisee, if the supervisor unjustifiably criticises the supervisee, the supervisee may experience anger that could lead to different reactions, according to the supervisee’s goals. Thus, the supervisee may feel motivated to preserve the relationship with the supervisor or may decide to enhance his or her self-identity that has been damaged by the supervisor’s criticisms. In the first case, the coping reaction would be to minimise the supervisor’s behaviour, or to think that he was right, or even to blame oneself. In the second case, a likely coping reaction would be to react by showing anger and letting the supervisor know that the supervisee feels he or she has been treated unfairly.

Inspired by the transactional model of stress formulated by Lazarus(1991), Stone and Neal (1984) identified eight coping strategies used by individuals and constructed one of the most used instruments for measuring coping, which I will describe below.

They attempted to construct an instrument to measure daily coping in longitudinal studies. In a pilot study, they asked participants to think of a recent problem and respond to 87 items. In a subsequent study the checklist was reduced to 55 items. Eight categories were found and these were labelled: distraction, situation redefinition, direct action, catharsis, acceptance, support, relaxation and religion. The definition of each coping strategy is provided in Table 3-1 . However, the psychometric properties of this scale turned out to be unsatisfactory. Stone and Neal (1984) decided that the rating scale did not seem an appropriate instrument. They then constructed an open-ended instrument, which allowed the 120 participants of the study to indicate which class of coping they used, as well as their specific thoughts and actions. A one-sentence description for each of the eight coping strategies was presented and participants were asked to check the appropriate category. This was considered an indicator of content validity; it was not possible, however, to compute internal reliability coefficients because the categories were single items. The results also suggested that similar types of problems experienced by an individual corresponded to consistent coping methods. The individuals used a variety of coping strategies. The study was also consistent with Lazarus's definition of emotion focused and problem focused coping, which was presented above. In particular, 'distraction', 'catharsis', 'acceptance' and 'relaxation' were identified as emotion focused

strategies. ‘Situation redefinition’, ‘direct action’, ‘seeking social support’ and ‘religion’ were identified as being problem solving coping strategies.

Table 3-1 Coping strategies and their classification

Coping strategy (Stone and Neal, 1984)	Definition
Distraction	Diverted attention away from the problem by thinking about other things or engaging in some other activity
Situation Redefinition	Tried to see the problem in a different light that made it seem more bearable
Direct Action	Thought about solutions to the problem, gathered information about it, or actually did something to try to solve it
Catharsis	Expressed emotions in response to the problem to reduce tension, anxiety or frustration
Acceptance	Accepted that the problem had occurred, but that nothing could be done about it
Seeking Social Support	Sought or found emotional support from loved ones, friends or professionals
Relaxation	Did something with the explicit intent of relaxing
Religion	Sought or found spiritual comfort or support

3.4 Summary

According to the Cognitive-Motivational-Relational Theory of Emotion (Lazarus, 1991), emotion is seen as being the outcome of an adaptational encounter. The model states that emotions arise due to an event, which always involves personal and environmental factors. These factors will create a certain person-environment relationship, which will have consequences for the personal well-being and goals of the individual. These consequences may be positive or negative and are often described in terms of ‘harm’ and ‘benefit’. This is the relational meaning of the event. Here, emotions have an adaptational function, for example anxiety will activate our defence mechanism and defend us from a

potential threat. However, if the appraisal of the situation is unrealistic emotions lose their adaptational role, for example an event perceived as frightening when it is not may cause unnecessary anxiety behaviours and defence mechanism activation. Coping is part of the appraisal process; it is individual and helps to handle difficult emotions. Figure 3.1 is a diagrammatic representation of the model.

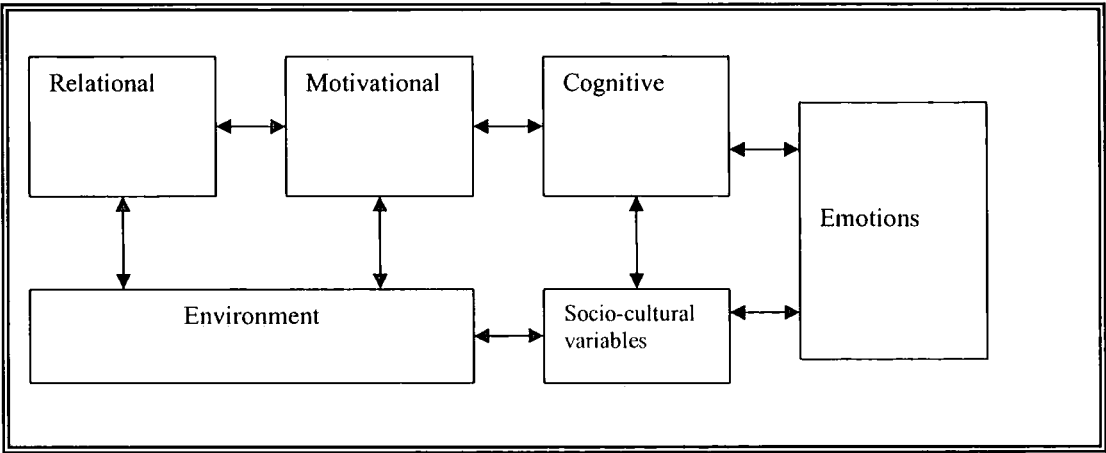
Compared to the other approaches illustrated in this chapter, Lazarus's model takes into consideration all the different variables that are present in the wider learning context, as described in Chapter 2. The other traditions focus only on one or two aspects of the Lazarus model, which correspond to the boxes of the diagram. For example, according to the evolutionary tradition described in section 3.2.1, emotions serve an adaptational role in different environmental situations. They also help to regulate interpersonal relationships. Furthermore, through an appraisal mechanism the individual identifies the different environmental situations and uses an appropriate behaviour each time. However, this is to ignore the role played by individual characteristics, such as motivation, and does not explain how different factors influence each other.

The biological approaches, for example the biofeedback theories, explore in depth the idea of the appraisal mechanism of emotional states, and describe how biofeedback signals from the body, for example muscular tension, are used to help tense and anxious people learn how to relax. However, they neglect the role played by the environment and socio-cultural variables.

The psychodynamic approaches recognise that emotions can affect learning. However, they assume that emotions are triggered by the individual’s internal states and past experience only. If compared to the diagram below, it is not clear whether there is a role here for the context in which the encounter is happening, that is relationships with colleagues, the environment, the individual’s cognitive capabilities and his or her motivation.

Similar conclusions can be drawn with regard to the behaviourists, who consider observable behaviour as being the result of interaction with the environment, overlooking other important variables.

**Figure 3-1 A simplified diagram of the Lazarus model of emotions**



**3.5 Statement of the Problem**

Although the influence of personal and environmental factors on the transfer of training has been studied, how trainees handle these barriers has not. It is possible that clinicians who are better able to overcome barriers to learning will experience higher levels of transfer of their skills with clients. In the previous chapter, I have already illustrated how



a pilot study has shown that training in ‘relapse prevention’ results in increased learning (Milne *et al.* 2002a). This may be due to the component in this training that enables trainees to have a degree of control over their transfer climate, by having control over the way they react to it.

It would be interesting then to study the way clinicians handle any other barriers to the transfer of their training. For example in a recent research study in which I was involved (Carpenter *et al.* 2007), two cohorts of MHPs attending a training course were asked to rate the perceived barriers to the implementation of new skills. These trainees identified a number of barriers to the use of their skills, of which the biggest was insufficient time and resources. Other barriers included a feeling that they had insufficient knowledge and skills, and the view that some users and carers did not believe in the interventions. Other possible barriers may be support and interest, beliefs in PSI (training) and KSA. However, the study did not directly investigate the coping strategies used by trainees in their learning and its transfer.

There is evidence that CS and training are difficult and challenging (Milne & Westerman, 2001), and that individuals who make use of coping strategies handle training better than those who do not. Similarly, improved ability to handle barriers to transfer should lead to improved transfer rates.

In the previous chapter, I have summarised research that claims that emotions play an important role in the acquisition of new skills and in the application of these new skills in

the workplace. For example, from the application of Kolb's theory, it emerged that the category he defined as 'experimenting' also implies 'an emotional accompaniments of action' (Milne *et al.* 2002). Warr and Downing (2000) demonstrated the link between anxiety and learning strategies; Kraiger *et al.* (1993) set out a model of training evaluation where affective outcomes play an important part. These and the other studies described in Chapter 2, could be useful in understanding the process of training and transfer and of CS, and why people often do not successfully implement newly learnt skills in the workplace.

The Lazarus model of emotions (1991) provides a potentially useful framework within which emotions, training and the transfer of training can be studied. This is because the model can describe any adaptational struggle that we encounter in life and so can be applied to the training situation. It is also a broad theory, which looks at the relationship between stress, coping and emotion; this is particularly relevant to the present research, because adult trainees often experience stress. Furthermore, the Lazarus model has never been used in a training, CS and transfer setting and has never been operationalised, at least in the training CS and transfer situation. Moreover, there is little information available on how a specifically designed intervention, based on this might influence MHPs' responses to training and supervision.

## **3.6 Conclusions**

The implementation of training in PSI in mental health services can sometimes be problematic, as illustrated in Chapter 2. Emotions have been identified by some authors

as having a potential role in influencing training outcomes. The problem addressed in this thesis is whether a theory of emotions can explain why MHPs may have difficulty in learning and in transferring skills and knowledge to practice. This thesis, therefore, aims to develop a model that can describe the role of emotions in training and its transfer to the workplace, and to explore how it may be operationalised and applied.

Subsequently, this investigation had three specific objectives. The first two were related to the model development, the third was a testing of the model in a real life situation. Specifically:

The first objective was to check the suitability of the Lazarus model to describe the emotions experienced by MHPs when undergoing training, including CS, and in their attempts to transfer their learning into practice.

The second objective was to measure the emotional responses of MHPs in a training programme and investigate whether these were associated with the extent to which they were able to implement their learning in practice.

The third objective was to test the model through an investigation of the possible interactions between stress, coping and emotions experienced by mental health professionals in the transfer of their learning into clinical practice.

My hypotheses were that:

- I. Emotions play an important role in both the acquisition and the transfer of new skills in a professional setting.
- II. The use of coping mechanisms facilitates the process of learning new clinical skills and their transfer

In order to achieve these objectives and to test the hypotheses, I employed the qualitative and quantitative research methods that I will describe in the following chapter.

## 4 RESEARCH METHODOLOGY

In the previous two chapters, I reviewed the general issues involved in the phenomena of learning and transfer of training by MHPs, considering emotions as a possible cause of poor training implementation. I concluded that research in this area has not been conducted systematically and more investigation needs to be done in real life situations.

### 4.1 Aim of the study

The aim of this thesis is to develop a model that can describe the role of emotions in training and its transfer to the workplace, and to explore how such a model may be operationalised and applied.

### 4.2 Objectives and hypotheses

This investigation had three specific objectives:

1. To assess the suitability of the Lazarus model for describing the emotions experienced by professionals undergoing training and in their attempts to transfer their learning into practice.
2. To measure the emotional responses of MHPs in a training programme and investigate whether these were associated with the extent to which they were able to implement their learning in practice.

3. To test the model through an investigation of the possible interactions between stress, coping and emotions experienced by MHPs in the transfer of their learning into clinical practice.

My underlying hypotheses were that emotions play an important role in both the acquisition and the transfer of new skills in a professional setting, and also that the use of coping mechanisms as described in the Lazarus (1991) model facilitates the process of training and its transfer.

In order to achieve these objectives, I employed qualitative and quantitative research methods and measures, which I shall describe and justify in this chapter. The work undertaken to achieve each of the three objectives is, for convenience, referred to as Study 1, 2 and 3 respectively. Table 1-1 summarises the objectives and methods. The table also indicates the participants in each Study.

### **4.3 Research Objectives and choice of Methodology**

1. The first research object was to describe the experience of emotions in training, CS and transfer (Study 1).

In order to describe the experience of emotions in training and transfer, I developed a theoretically grounded semi-structured interview schedule for use with MHPs. The method was designed to verify the presence or otherwise of emotions experienced by

trainees and in particular, to investigate whether the three main variables (cognitive, motivational and relational) of the Lazarus model (1991, 2000) were evident.

As I have illustrated in the first two chapters of the thesis, there has been no explicit investigation of this particular subject and I have not found any relevant research instrument. Kazdin (2002, p.121) recommended that by using an exploratory, qualitative approach, future testable research hypotheses can be generated, through the gathering of detail-rich data that serves as a method to enhance understanding. He stated that the goal of qualitative research is to “Describe and interpret experience, provide new insights, describe and explain with few or no initial hypotheses” (Kadzin, 2002, p. 250). Qualitative methods, for example interviews, usually serve this aim. In particular “qualitative research is an exploration, elaboration and systematisation of the significance of an identified phenomenon” (Parker, 1994, p.3).

Coolican (1999) described the semi-structured interview as the interview style of choice in qualitative research. With semi-structured interviews, the investigator has a set of questions on an interview schedule, but the interview is “guided” by the interview schedule rather than “dictated” by it (Smith, 1995, p.16). Thus, there is an attempt to establish a rapport with the participant and the interviewer is freer to follow the respondent’s interest of concern. Therefore, this technique tends to produce rich and in-depth data.

Furthermore, qualitative research usually allows flexible research design, and data is often collected in a setting that is familiar to the respondent. However, the sample is usually small and is selected purposively to include participants who are considered likely to be able to represent a range of views on the topic under consideration (Kadzin, 2002).

2. The second objective was to measure the emotional responses of MHPs in a training programme and investigate whether these were associated with the extent to which they were able to implement their learning in practice (Study 2).

If the presence of emotions, and if the three main variables of the Lazarus model have been verified through the interviews, it should be possible to operationalise and if necessary extend the Lazarus model. I therefore had to design an instrument in the form of a self-completion questionnaire to measure emotions both in training and in transfer, and to assess its psychometric properties.

With this measure, I was then able to investigate possible associations between the emotions experienced in training and the extent to which trainees implemented their learning in practice. However, in anticipation of the survey method described below, I took the opportunity of using part of the interview sample in Study 1 (N=11) to undertake a preliminary investigation of the relationship between the emotions expressed and the reported transfer rates of learning.



The primary research design of this second study was correlational. I used a cross-sectional survey, including the above mentioned questionnaire (measuring emotions) and another previously validated instrument to measure implementation. In addition, the use of questionnaires would allow possible confirmation of the findings of Study 1 to a larger, more representative sample. The purpose of the design was to correlate emotions in training and transfer in order to test the first hypothesis.

Quantitative studies are generally used when the researcher has a clear hypothesis and theory to test or to identify causal relationships using experimental methods (Kazdin, 2002), as for example that emotions play an important role in both the acquisition and the transfer of new skills in a professional setting.

Anastasi and Urbina (1997) outlined several interesting points regarding the use of questionnaires. They considered that self-reported questionnaires are a way of gathering empirically based information relatively quickly and simply and can be used with larger samples. However, sometimes the construction of such an instrument can be quite complicated, as it has to be not only theoretically based, but has to respond to strict psychometric characteristics. Questionnaires are considered to be “objective” in the sense that the score achieved is not affected by the beliefs and opinions of the person who administers the questionnaire, or of those who fill in the questionnaire. However, these beliefs and opinions may sometimes distort the interpretation, and there are many ways in which the person filling in the questionnaire may distort his or her responses. These are as follows:

- Random answering; when the respondent deliberately answers the questionnaire in a random way. Such lack of co-operation may reflect a general resistance to the idea of being tested, or a reaction to a particular measure considered too intrusive, such as a personality inventory or a questionnaire about personal emotions. The likelihood of random answering may be reduced with careful and correct test administration, for example clearly explaining the aims of the study.
- Intent to distort; this is more likely to happen in a personnel selection setting, when as part of the selection procedure candidates are requested to fill in questionnaires, or in clinical setting where the client may attempt to influence the likelihood of receiving treatment by exaggerating his or her responses. Again, in this case the way the instrument is presented is very important.
- Low degree of self-insight; in order to accurately answer the questions of psychological questionnaires designed to measure personal variables, such as emotions, the individual must have a minimum level of self-awareness, which can help them to identify their feelings. People differ in their level of self-insight and constructing simple items and giving a few examples might be useful.
- Acquiescence, which is the tendency to agree with items regardless of their content. One way of dealing with this is to balance the number of items for which a certain rate, for example a high or low level of agreement, is desirable.
- Socially desirable or undesirable responding. This may well be a conscious attempt to distort, but there is an unconscious component as well. For example, it may be part of an individual's temperament to report more positive or negative aspects. For example,

a person with low self-esteem will more readily access their less favourable aspects or point to negative feelings and emotions.

Despite the distortions referred to above, quantitative data derived from a standardised questionnaire can allow for the use of a larger sample size. For example, the administration of a questionnaire to groups of MHPs attending a training course to obtain statistically meaningful data that can be generalised to the population concerned. So, for example I could measure the presence of emotions in training and transfer and the data analysed using an appropriate statistical test in order to draw conclusions regarding that sample of trainees, and then possibly extend these conclusions to MHPs in general.

3. To test the model through an investigation of the possible interactions between stress, coping and emotions experienced by MHPs in the transfer of their learning into clinical practice.

As I have illustrated above, the first two objectives of the study are concerned with developing Lazarus's model, the third objective is an attempt to test it in a real situation. According to Kazdin (2002), one effective way to attempt to understand a psychological concept is to study it in an applied setting. In order to achieve this objective, I worked with a colleague, Dr. Derek Milne, a senior clinical psychologist who was mainly responsible for the design and implementation of an intervention in the form of "revitalised" clinical supervision (RCS). Using a "N= 1" multiple baseline case study design I assessed the effects of the intervention in a 'real life' practice setting. The

purpose of the design was to reveal any associations between a specific intervention and the use of positive coping strategies, and improved transfer rates. (hypothesis 2) .

I asked the participants in this study to keep a daily self-report diary. This instrument was chosen as it allows intensive analysis of the possible variables influencing transfer (Fleming *et al.*, 1996; Hersen & Barlow, 1984). As measurements occur daily, the processes of transfer and coping can be captured, and recall bias is also limited. Daily use of the diary is important due to the transactional nature of coping (Stone & Neale, 1984). Tennen and Affleck (1996) provided a rationale for the use of daily coping. First, in the Lazarus transactional model, interactions result in continuous change throughout the coping process. Coping is usually regarded as a “dynamic process that changes over time” (Stone & Neal, 1984, p.892), and minor events have been found to more strongly relate to psychological symptoms than major events. Daily diaries allow the analysis of this aspect within subject variability and help to understand how individuals cope with different kinds of problems. Furthermore, it is more practical compared to other instruments, such as interviews. It does not take long to complete and respondents can fill it in in their own time (e.g. outside their working hours). Secondly, a repeated measure format helps to minimise any biases and distortion introduced by retrospective recall. Finally, it focuses on micro processes that can better detect causal relationships; for example, coping strategies have been associated with same-day moods in studies employing a daily design (Stone *et al.* 1992).

A case series analysis was chosen as it can highlight important associations and variability, both within and between participants, allowing the associations between coping, affect and transfer to be studied in depth. Individual coping strategies, affect and rates of transfer can be observed. Small N designs (including N=1 and case-series designs) are considered to be appropriate when assessing possible associations and variability within and between participants (Hersen & Barlow, 1984). In this design, the supervisees served as their own control, each receiving the intervention, ("revitalised" supervision, described below) in turn. As suggested by Kadzin (1989), data were collected continuously and concurrently on more than two behaviours. The observed behaviours were the use of coping strategies, sense of mastery and strain, stress and transfer. The effects on the independent variable (participation in Revitalised Clinical Supervision) were observed in the eight different coping strategies (distraction, situation redefinition, direct action, catharsis, acceptance, seeking social support, relaxation and religion) included in the daily diaries.

The case-series analysis allows for both within- and between- participant comparisons and is recommended for studies of training (Fleming *et al.*, 1996), or in those situations where the researcher wants to test the effect of an intervention. Conventionally, in order to test the effects of an independent variable, two groups are required: the experimental group, for example MHPs receiving CS, and a control group, for example MHPs receiving no CS. However, this is not always possible for practical reasons; for instance each group requires quite a large sample, for example 15-20 participants per group).

Also, in the present case, it might be unethical to conduct the study on a large scale before it had been demonstrated to be a successful avenue to explore.

#### ***4.3.1.1 The Intervention: Revitalised Clinical Supervision***

Revitalised Clinical Supervision (RCS) was developed following suggestions from research, that has demonstrated that supervision needs to involve a range of methods if it is to enhance competence (Watkins, 1997), and introduce more experiential elements as suggested by Kolb (1984) (section 2.9.2), for example those based upon verbal, visual, behavioural and affective/emotional modes.

RCS was designed following meetings with a senior clinical psychologist, a NHS manager and a supervisor, where the structure of the actual supervision was discussed, and weaknesses identified (such as lack of a variety of methods as suggested by Watkins, 1997).

RCS essentially added more experiential, formative methods to the existing approach, which featured largely “normative” and “restorative” methods. “Normative” methods involve the development of organisational responsibility, for example making time available for sessions. While the “restorative” methods are linked to the support and well-being of the individual, for example discussing personal issues. The RCS included the use of experiential methods, such as “role play” and “live” supervision, that is supervision during routine clinical work, and goal-setting for the next week’s clinical work.



Furthermore, the intervention was designed following the transactional model of emotions (Lazarus, 1991), where particular importance is given to particular emotional/stressful events experienced by the supervisee when working with clients. The role of the supervisor was to analyse the supervisees' appraisal mechanisms. For example, analyse the supervisee's perception of why an event was stressful, and comment on the coping strategies that were used. In fact, during the RCS session, regular feedback on the completion of the diary was provided by the supervisor. Particular importance was given to the discussion of difficulties in implementing PSI techniques when working with clients, which could cause stress to the supervisees. Additionally, the supervisees were encouraged to use their coping strategies to reduce stress and anxiety, promote a sense of mastery and positive emotions, and to work better with their clients.

#### **4.4 Summary**

The main question of this thesis was whether the Lazarus model of emotions (1991, 2000) can help to understand why MHPs often do not implement their newly acquired skills when working with their clients. There were three key objectives, and in order to address these I conducted three related studies. The first two studies consisted of an investigation of the suitability and operationalisation of the Lazarus model (1991, 2000). The third study was a test of this model in a real life situation. Each of the studies used a different design, samples and instruments of data collection.

4.5 Instruments

This section will explore the different instruments used in the research. For each of the three studies, I will describe the measures, how they were constructed and their structure. Table 4-1 below is a summary of the different instruments used in each study. In addition, all participants completed a Demographic Questionnaire (Appendix 3).

Table 4-1 Summary of the three instruments

	Instrument
STUDY 1	Affect in Training interview Affect in Supervision interview GQ (trainees only)
STUDY 2	Affect in Training Questionnaire GQ
STUDY 3	Daily Coping Diary

4.5.1 Semi-structured affect in training/clinical supervision interview

A semi-structured interview was developed to describe the experience of training, CS and transfer. All the participants were interviewed, and part of the sample filled in an instrument that measured transfer rates.

The interview schedule was constructed following Smith’s suggestions (1995). These recommendations are described below:

1. First of all, the overall issue to be tackled in the interview was determined, and then related themes were looked at. In the case of the present interview, these were training, CS, transfer, barriers, boosters and significant emotional events.



2. Secondly, these themes were structured in the most appropriate sequence. Again, following Smith's suggestion (1995), the interview was constructed in three parts, based on describing, interpreting and explaining emotion in training and transfer, following Kazdin's definition of qualitative research (2002), as illustrated in Table 4-2. According to Kazdin (2002) the goals of qualitative research are to "describe and interpret experience; provide new insight, describe and explain with few or no initial hypotheses" (p.250). The sequence of questions began with a question on learning, followed by a question on the transfer of skills back to the work-place (Table 4-3).
3. Thirdly, questions related to each area were constructed in order to investigate the research topic. To encourage the participants to speak about their emotions spontaneously, broad rather than explicit questions on emotions were used. This technique, suggested by Smith (1995), helps the interviewer to be neutral, rather than leading and it was thought to be useful in the present research, so as to verify whether emotions were present in the trainees' and supervisee's experiences.
4. Finally, Smith (1995) suggested thinking about possible probes and prompts, with which to follow up answers that have not been clear, or which could be used when a respondent asks for an explanation. The prompts of the present interview were specifically drawn from both the literature on training and the literature on emotions. For example, for the first question (How would you describe the general experience of PSI training?) the related prompts were: "environment, attitudes, support, usefulness of training". These took into account the considerations of the main

literature, such as the relationship with the environment (Lazarus, 1991), the individual's attitude (Kraiger *et al.*, 1993) and relational aspects and appraisal of the situation (Lazarus 1991).

**Table 4-2 Content of the semi-structured affect in the clinical supervision Interview.**

Kazdin definition (1998)	Section	Content
Describe The general experience	Content/ effectiveness	Description of supervision/training session, rating of supervision experience, success of transfer of skills learnt
Interpret, elicit understanding of trainees	Barriers/Boosters	Anything during the sessions that limited the learning/transfer, or enhanced learning/transfer
Explain The experience	Significant emotional events	Positive or negative events during supervision, and during transfer, with prompts of emotions taken from Lazarus's model
	Suggestions	Interviewee is invited to add any comments about how supervision/training might be improved to give them more confidence/competence, for example

The questions of the interview were also constructed following Smith's (1995) suggestions. These were as follows:

1. Questions should be neutral rather than leading.
2. Questions should avoid jargon so they are understandable.
3. Closed questions should be avoided, encouraging more drawn out answers.

A small introductory paragraph was inserted at the start of the interview schedule, to explain the purpose of the study and the estimated duration of the interview. Confidentiality and the possibility of stopping the interview at any time were clearly

stated. The participants were also given the option to receive some feedback on the results of the study.

The interviews consisted of ten qualitative questions and seven quantitative questions. The quantitative questions were related to the qualitative questions that preceded them and the participants gave their responses on a scale of one to five. The questions had to do with both the training/supervision (How would you describe the PSI training?) and the experience of transferring the skills when working with clients (How successful do you think you were in applying the PSI skills to the workplace?). Following the work of Milne *et al.* (2000b), questions on “barriers and boosters” to learning were included to find out about the positive and negative aspects involved. Examples of these questions are: “Was there anything in the PSI training programme itself that limited your learning in the classroom?” and “What do you think made it difficult to use the PSI training skills with your clients?” Finally, the participants were asked about the most significant emotional event that had occurred both during training and transfer. This followed Hook and Bunce’s (2001) idea of identifying factors other than the technical content of the interventions that may affect the outcome. Hook and Bunce (2001) suggested that this methodology “has considerable potential for the understanding of learning outcomes in organisational training research” (p.438).

**Table 4-3 Interview schedule: affect in training/clinical supervision interview**

Section of the Interview	Question
Description of content of training/ clinical supervision and transfer success	1. How would you describe the PSI training/clinical supervision session?
	1b. How would you rate the PSI training /clinical supervision session overall?
	2. How successful do you think you were in applying the PSI skills/skills discussed during clinical supervision to the workplace? 2b How would you rate the general success of applying PSI skills to the workplace?
Barriers and Boosters	3. Was there anything in the PSI training programme/clinical supervision session that limited your learning? 3b. To what extent did this limit the success of your training/clinical supervision experience?
	4. Was there anything that made it difficult to use the PSI skills with your clients? 4b. To what extent do you think this limited the success of using the PSI skills you learnt with your clients?
	5. Was there anything in the PSI training/clinical supervision that improved the success of the PSI programme? 5b. To what extent did this contribute to the success of your training/clinical supervision session?
	6. Was there anything in the PSI training/clinical supervision that contributed to the success of the implementation of the PSI skills? 6b. To what extent did this contribute to the success of the implementation of the PSI skills?
	7. Taking into account what you have said about barriers and boosters, to what extent have you felt able to a) learn; b)transfer
Significant emotional event	8. Of the events that occurred during the PSI training course/clinical supervision session, which ones do you feel were the most significant emotionally? 9. Of the events that occurred when applying PSI skills to the workplace, which ones do you feel were the most significant emotionally?
Other	10. Would you like to add any other comments before we finish the interview? In particular, is there anything else you would like to say about the emotional aspect of the PSI training/clinical supervision sessions and the use of these skills with clients?

#### 4.5.2 The Generalization Questionnaire

In anticipation of the survey methods employed in Study 2, the second instrument used in Study 1, and then in Study 2, was the Generalisation Questionnaire, constructed by Milne *et al.* (2000b). It was used to assess the transfer (generalisation) of the PSI training course to the workplace. As I will describe in section 4.8.1, only part of the sample was asked to fill in this measure.

The questionnaire contained a list of 13 PSI instruments and interventions, such as the “social functioning scale”, and anxiety management and social functioning, on which participants were asked to note whether each had been utilised in the three months before and after the training course. The original questionnaire also asked participants to list the approximate number of clients the PSI approaches had been applied to, the clinical impact of the work, and any generalisation across behaviours, persons and responses (Milne *et al.* 2000b). The latter three options were excluded from the final questionnaire distributed for this study, for reasons of simplicity. This questionnaire was thought to be suitable for the present study as it has been employed with a similar population (MHPs). The questionnaire has also good test-retest reliability ( $r=0.57-0.86$ ;  $p \leq 0.001$ ).

A simplified questionnaire was used in this study (Appendix 8). It contained a list of instruments encountered in the PSI courses and the participants were only required to mark how often they had used all of the instruments before and after the training course using a numerical score (e.g. 5= extensive use/1= never used). It also measured the trainees’ experience and perceived clinical effectiveness.

4.5.3    The Affect in Training Questionnaire

To assess the role of emotions in training and transfer, a questionnaire was developed specifically for this project, using constructs from the applied psychology literature, specifically from psychotherapy, organisational and training research. The questionnaire was designed following Rust and Golombok’s (1989) suggestions.

The first step was to make clear the purpose of the questionnaire, which, in this study, was to measure emotions in training and transfer, following Lazarus’s model. Secondly, Rust and Golombok suggested the creation of a “test specification” (1989, p.144), with different content areas. These should cover everything that is relevant to the purpose of the questionnaire. The different content areas (Table 4-4) of the instrument were selected both from the Lazarus model (1991) and from the relevant related literature in order to include other factors within the three categories (cognitive, motivational and relational) described by Lazarus

Table 4-4 Extended Lazarus model of emotion

ASPECTS OF LEARNING	VARIABLE/ITEM
Cognitive	Knowledge (Declarative/Procedural)1* Appraisal (Primary/Secondary) 1 Metacognition2*
Motivational	Attitudes2 Motivational disposition (Mastery/Performance orientation) 2 Goals1 Self-efficacy2
Relational	Benefit1 Harm1 Physical environmental factors2 Warmth2 Empathy2 Support2
Affective	Effect of emotions2

\* 1= items specifically stated in the original model. 2=additional items.

I now will illustrate these content areas, referring to the relevant literature. The cognitive aspects of the Lazarus model included the variables of appraisal and knowledge, along with the addition of metacognition. As already set out above, Lazarus (1991) indicated two types of appraisal. Primary appraisal is the initial personal evaluation of a situation. This determines the goals set and the appropriate behaviour. Secondary appraisal refers to the evaluation of the individuals' coping abilities. Procedural knowledge, that is the knowledge and information about 'how' to execute a particular skill, was mentioned in the original Lazarus model. Following Kraiger *et al.* (1993), declarative knowledge was added to this adapted model, this refers to information about 'what' something is, or general knowledge other than skills. Each of these variables may influence the direction of the appraisal. For instance, the degree of the individuals' knowledge (procedural or declarative) may determine their initial appraisal (harm or benefit), which may then determine their coping abilities. The concept of metacognition, as proposed by Kraiger *et al.* (1993), involves the knowledge and awareness of one's cognition, which includes planning and goal-appropriate behaviours.

Within the motivational section of the extended model, attitudes, motivational disposition and self-efficacy were added. Kraiger *et al.* (1993) suggested that attitudes are feelings (positive or negative) towards an object. This internal state will then exert an influence upon subsequent choices of action. Two identified types of motivational disposition were included as motivational factors in the extended model. Firstly, mastery orientation is the individual's determination to increase their own understanding and competence in a given task. Performance orientation is the intention to do well to gain a positive

evaluation from others. It has been suggested that mastery orientation leads individual's to make internal attributions for success and failure, and to see learning as personally determined. However, individuals with a performance orientation will set their goals towards receiving approval from others (Dweck & Leggett, 1988). As goal-setting is mentioned as influencing motivation, it was thought to be an important aspect to include in the extended model as well as self-efficacy (Salas & Cannon-Bowers; 2001), although it is the only area that was not covered in the Lazarus's model.

The relational aspect of the extended model included the additional factors of support, warmth and empathy, and physical environmental factors. Colquit *et al.* (2000) defined support as the validation of one's effort during the training/transfer situation (p. 681). They conducted meta-analysis on factors influencing training motivation and found peer and supervisor support to be highly correlated with the motivation to learn. Empathy is conceptualised as the degree to which trainees believe that the trainer has understood their problems, and helped them, during and throughout training (Hook & Bunce, 2001). Additionally, warmth can be defined as the atmosphere that develops between trainees and trainer. This may influence the amount of the individual's learning, as well as the amount they transfer. Smith and Spence (1980) suggested that the physical environment is also important. The training environment may have an effect on the trainee, and so affect their appraisal of the situation.

Furthermore, a list of emotions was added, affect in training and affect in the workplace. These were drawn from the literature (Lazarus, 2000) and, after consultation with a



senior clinical psychologist, differentiated into positive and negative, for example anxiety was seen as a negative emotion and pride a positive one.

Once the content areas had been identified, the next step was to develop items that could assess these variables. According to Rust and Golombok (1989), a minimum of 20 items is usually required to achieve good reliability. Two items per variable were selected from existing questionnaires; other items were constructed using the definitions of the relevant variables included in the extended Lazarus model, giving a total of 47.

These were all “rating scale items”. The participants were asked to rate their agreement with each item, on a 5-point rating Likert scale (ranging from “1=strongly disagree” to “5=strongly agree”). The advantages of rating scale items is that respondents feel able to express themselves more precisely, than for example with alternate choice items. However, respondents may differ in their interpretation of the response options, for example “frequently” has a different meaning for different individuals, or some may tend to choose the most extreme option (Rust & Golombok, 1989). Despite the limitations of Likert scales, it was felt that these were outweighed by their advantages in this study.

The next stage into the development of the questionnaire involved the division of the items into four sections. The first three covered the motivational, cognitive and relational aspects of learning. Thus, from this extended Cognitive-Motivational-Relational model, the Affect in Training Questionnaire (ATQ) was constructed. Next, in the fourth section of this questionnaire a list of positive, (for example excitement), and negative, (for

example boredom), emotions was provided. The participants were asked to rate the extent to which these emotions were experienced, both during the learning situation and during transfer to the work setting, when applying the PSI skills with their clients. This was also rated on a 5-point-scale (ranging from “1=never” to “5=always”).

Table 4-5 ATQ: content area of the motivational variable

MODEL VARIABLE CONSTRUCT	VARIABLES MEASURED	INSTRUMENT OR SOURCE ITEM	ITEMS
MOTIVATIONAL ASPECTS OF LEARNING	Attitudes	BARQ	The training is effective with my clients I think the training was a valuable use of my time
	Motivational disposition: Mastery orientation	Kraiger <i>et al.</i> (1993)	The training is appropriate for my clients I am keen to increase my competence in PSI (for example by learning from my mistakes)
	Motivational disposition: Performance orientation	Kraiger <i>et al.</i> (1993)	I am keen to use PSI, so others respect the way I work (especially colleagues) It's important for me to get it right, so others' approve of the standard of my work (including users)
	Goals: achievement and commitment	Kraiger <i>et al.</i> (1993)	The goals of the PSI training are achievable, for example the level of training is appropriate and the goals are sufficiently clear I am committed to the aims of the PSI training
	Self-efficacy	Sherer <i>et al.</i> (1982)	I may give up if I am not initially successful with the PSI approach If at first I can't do PSI as part of my job, I'll keep trying until I can
		Suggested by PSI manager	I see the PSI approach as having the "right" value base, for example, the empowerment of staff and treatment of users as partners

Table 4-6 ATQ: content for the cognitive scale

MODEL VARIABLE CONSTRUCT	VARIABLES MEASURED	INSTRUMENT OR SOURCE OF ITEM	ITEMS
COGNITIVE ASPECTS OF LEARNING	Knowledge: Declarative and Procedural	Kraiger <i>et al.</i> (1993)	I have a sound knowledge of PSI I know what I need to do to apply PSI
	Appraisal: Primary	Coping Response Inventory (CRI) (Moos, 1990)	I think of PSI as a threat to my competence I think that using the PSI training with my clients is an interesting challenge
	Appraisal: Secondary	CRI Lazarus (1991) p. 827	If I encounter difficulties, I will consider different options for using PSI I have coped with training like this before I have applied similar training with my clients before
	Metacognitive: Awareness and Regulation	Meta-Evaluation- Scale (Mayer & Alexander, 1994)	I know how I feel about PSI, for example positively or negatively Regulating my feelings or general mood helps me to learn about PSI and transfer it to my clients, for example improving how I feel by thinking positively or “dampening” a more excitable mood by calming myself down Sometimes I think I should be doing more in terms of PSI, for example using it more often

Table 4-7 ATQ: content area of the relational variable

MODEL VARIABLE CONSTRUCT	VARIABLES MEASURED	INSTRUMENT OR SOURCE OF ITEM	ITEMS
RELATIONAL ASPECT OF LEARNING	Benefit	CRI	I talk with someone involved, for example a peer or supervisor, in order to get the most benefit from the PSI training
	Physical environment	Suggested by PSI manager	The teaching/learning environment is suitable physically, for example the levels of temperature and noise The organisation has systems in place to support PSI, for example, supervision arrangements, steering groups and audits
	Harm	CRI	The training environment feels safe, for example we all co-operate, and making mistakes is OK
	Environmental factors: Warmth and Empathy	Hook and Bunce (2001)	I felt that the atmosphere in the training session was warm and relaxed I felt the trainer (tutor) understood the problems that I faced, for example during the training or in applying it
	Environmental factors: Support	Colquitt <i>et al.</i> (2000)	There are managers (and others) who support my PSI efforts, for example, by “talking it up”/ championing My other colleagues at work support my participation in the PSI learning activities

Table 4-8 ATQ: content area for affects

MODEL VARIABLE CONSTRUCT	VARIABLES MEASURED	INSTRUMENT OR SOURCE OF ITEM	ITEMS
RELATIONAL ASPECT OF LEARNING	Benefit	CRI	I talk with someone involved, for example a peer or supervisor, in order to get the most benefit from the PSI training
	Physical environment	Suggested by PSI manager	The teaching/learning environment is suitable physically, for example the levels of temperature and noise The organisation has systems in place to support PSI, for example supervision arrangements, steering groups and audits
	Harm	CRI	The training environment feels safe, for example we all co-operate, and making mistakes is OK
	Environmental factors: Warmth and Empathy	Hook and Bunce (2001)	I felt that the atmosphere in the training session was warm and relaxed I felt the trainer (tutor) understood the problems that I faced, for example during the training or in applying it
	Environmental factors: Support	Colquitt <i>et al.</i> (2000)	There are managers (and others) who support my PSI effort, for example by “talking it up”/ championing My other colleagues at work support my participation in the PSI learning activities

#### **4.5.4 The Daily Coping Diary**

The Daily Coping Diary (DCD) was designed to record any possible effects of the intervention in connection to coping, stress and emotion, as defined by Lazarus (illustrated in Chapter 3), and to record the transfer of training. It is based on validated existing instruments. It is divided into five sections, from A to E, described below.

Section A was based on the initial question of the Daily Coping Assessment (DCA) (Stone & Neal, 1984), already described in Chapter 3 (described in Section 3.3.5.1 and summarised in Table 3-1). This section is composed of two questions. Question 1 is open-ended and records the event that prompted the participant to attempt to use the PSI method. Question 2 is in the form of a 10-point rating scale ranging from “not at all” to “very much”, which measured the degree of stress felt in reaction to this anchored stressor.

Section B was records how often each of the eight coping strategies listed has been used. These coping strategies were taken from Stone and Neale’s DCA (1984). This device consisted of 10 statements, from “a” to “i”, for example “I tried to see the stress in a different light that made it seem more bearable”. Statements from “a” to “h” are 10-point rating scales, while statement “i” (did you use any other methods of coping, for example supervision?) adds an open-ended option. The participants were again required to indicate the frequency of use of each coping strategy from “not at all” to “all the time”.

Section C measures the emotions evoked when trying to cope with the stressful event. Respondents were provided with a list of 18 emotions experienced during transfer adapted from the ATQ and asked to tick those that they had experienced in connection to that event. There was also the opportunity for participants to indicate any other emotions they had felt. There was again a 10-point rating scale measuring the degree of distress experienced overall. The ratings were from “1=felt very distressed”, for example when respondents felt lots of anger and negative feelings, to “2=felt very good”, that is they had a sense of coping well, of mastering things, for example feelings of pride or happiness.

Section D measures the amount of transfer taken from the Generalization Questionnaire (Milne *et al.* 2000b). Respondents were asked to tick which PSI methods had been used and to indicate the frequency of use. In the transfer part, a list of PSI techniques was provided and participants were required to tick the ones they had used that day. There was also an opportunity for them to add ones they had used that were not included on the list. The frequency had a 10-point rating scale, which recorded how often the ticked PSI methods had been used. Participants were required to rate the frequency of use ranging from “1=never used” to “10=extensive application”.

In section E participants were asked to add any further comments, in response to an open-ended question.



Table 4-9 The Daily Coping Diary: constructs, variables and source of items

MODEL CONSTRUCTS	VARIABLES MEASURED	SOURCE OF ITEM
Section A: Stress	Perceived stressor	Stone and Neal (1984)
Section B: Coping	4. Distraction 5. Situation redefinition 6. Direct action 7. Catharsis 8. Acceptance 9. Social Support 10. Relaxation 11. Religion 12. Other	Stone and Neal (1984)
Section C: Emotions (positive and negative)	Sense of mastery versus distress	ATQ
Section D: Transfer of Training	PSI techniques	Generalisation Questionnaire (Milne <i>et al.</i> , 2000b)
Section E: Further comments		Present Researchers

As the DCD was based on existing instruments, reliability and validity data already existed for its components, as described below.

Sections A and B. Stone & Neale (1984) regarded their DCA as valid, although with potential weaknesses, such as its reliance on self-report. They checked the content validity of the coping items by asking participants to include written descriptions of their coping styles, in addition to choosing a coping category provided; an analysis of these descriptions revealed that they were appropriate to the categories. Internal reliability coefficients were not relevant and no data were presented. However, as the categories themselves were single items, reliability was suggested by the relationships of coping to the characteristics of the problem to be coped with, and to the individuals that were coping with them. For example, the perceived stressfulness of the problem was related to certain coping styles,

similar problems were handled in similar ways, and the gender of the individual also appeared to affect coping.

Section C. Reliability and validity of the affect scale of the ATQ are described in detail in Chapter 5. However, I can anticipate here that the scale had good internal reliability scores (0.7 for the negative emotions, and 0.8 for the positive emotions).

Section D. The test-retest reliability of the Generalization Questionnaire (Milne *et al.*, 2000b) gave correlations of 0.57-0.86, all significant at the 1% level, as described in section 4.5.2.

**4.6 Sampling**

Three different opportunity samples were used in the present research, one for each study. The paragraphs below describe the inclusion and the exclusion criteria adopted to recruit the participants of the three studies, then the recruitment procedure of each sample is outlined. Table 4-10 below is a summary of the different samples used in each of the three studies.

**Table 4-10 Summary of the three samples**

	SAMPLE
STUDY 1	Mental health professionals undergoing learning experiences: professional training workshops or clinical supervision
STUDY 2	Mental health professionals attending professional training workshops
STUDY 3	Mental health professional receiving “revitalised” clinical supervision

### 4.6.1 **Inclusion and exclusion criteria**

The inclusion criteria was that participants were health and social care professionals working in mental health services and currently involved in a post-qualification learning situation, (training or CS), in PSIs. I acknowledge that there are differences in the context in which the learning was happening, for example between training and CS, and I highlight these differences in the results, for example in section 5.1.2. Although these differences might signify a limitation for the generalisability of the research, the focus of this thesis is on learning processes and how these are influenced by emotions across settings and samples. No particular exclusion criteria was adopted.

In the following paragraphs, I will describe the recruitment procedures for each of the three samples used in the three studies.

#### ***4.6.1.1 STUDY 1***

The MHP participants for this study were recruited from two sources, a group of staff currently attending PSI training and another that had been receiving CS in PSIs, for a total of 21 interviewees. The interviews took place between May 2001 for those attending PSIs training, and February 2002 for the staff receiving CS in PSIs. These two groups of participants will now be referred to as trainees (for those who took part in the training programme) and supervisees (for those who received CS). The sequence of events to which participants were exposed when interviewed was standardised (described in section 4.8.1) in order to minimise external effects, such as time delay.

The trainees in this sample were attending a part-time, in-service training course, for a total of 10 days. They were social workers, occupational therapists (OT), and care-coordinators (demographic characteristics on Table 5-1). I visited them while they were attending the course, I explained the aim of my research and then asked them to take part in the interview. Fifteen people out of 18 volunteered and signed a consent form (Appendix 1). These 15 volunteers were contacted by telephone by myself, to arrange a convenient time for the interview to be held. They had the opportunity to choose between a telephone, or a face to face interview; 11 people were then interviewed. They were all sent the interview schedule (Appendix 4) prior to the interview. The remaining four, when contacted by telephone, declined to be interviewed and withdrew their consent, due to time restrictions.

The supervisees were mainly Community Psychiatric Nurses (CPNs) and social workers who had received regular CS (approximately one hour, once a month) as part of their clinical activity during the previous year. They belonged to integrated and specialist community based multi-disciplinary teams and were recruited following regular project steering group meetings with their key managers. These managers (who were also clinical supervisors) received a pack by post, which included a letter explaining the research, the consent form (Appendix 2) and the Interview schedule (Appendix 5). These were both passed on to their supervisees. By returning the consent forms the supervisees volunteered to participate. Fifteen supervisees (from a potential of 50) were approached by their managers and 10 agreed to participate and were then interviewed. As with the trainees, supervisees

were given the opportunity to decide whether to be interviewed by telephone or face-to face.

I acknowledged the ethical implications of such recruitment procedure in section 4.7 later in this chapter.

This opportunity sampling therefore included participants who had had experience of PSI training and/or clinical supervision, thereby providing a comprehensive coverage of the criteria for training delivery and implementation specified by Salas and Cannon-Bower (2001) discussed above (section 2.10.2). The aim of this study was not to compare the two samples, as both groups are considered “learners”, but to enable a full understanding of the process of learning and transfer. In section 5.1.1. (p. 144) I will report the results from the Demographic Questionnaire, where full details of the sample characteristics are presented.

##### **4.6.1.2 STUDY 2**

The participants for Study 2 were recruited from five courses for qualified practitioners from different disciplines, including social work and nursing. They were contacted through their managers, or recruited through the tutors of the course. Approximately 18 people attended each course. These were short in-service training courses, lasting ten days. The fifth course was a two-year part-time university based programme.

### **4.6.1.3 STUDY 3**

The sample for Study 3 consisted of mental health clinicians that had previously received training in PSI methods and were currently receiving CS in PSIs. This group of clinicians was different from that of Study 1. The participants of this third study had been offered RCS from their supervisor in order to put these methods into practice. The supervisor was a mental health professional qualified in PSIs, who took part in the design of the intervention. The ingredients of RCS are described in section 5.3.2

The study-three participants were contacted through their manager, who had volunteered his team for the study. He explained the study to the supervisees and gave them a consent form (Appendix 1) and a project information-sheet, which included the pros and cons of participating in the study. The consent forms were signed and returned to me through the care manager.

The methodology described above arose some ethical concerns, for example related to the recruitment of the sample, or the stress they might have perceived when taking part in the research. Key elements on how to conduct research ethically and how they can be related to the present investigation are described in the section below.

## **4.7 Ethical Considerations**

In this section, I will explore the ethical dilemmas that I encountered in my research and the attempts I made to solve them. Some ethical considerations arose

concerning the methodology described above. The British Psychological Society (1993) provided guidance on how to conduct research ethically. These are:

- Consent

This is the first element of conducting ethical research, and is defined as “informing the participants of the objects of the investigation” (BPS, 1993, p.9). In the present research, this was done through a consent form, as illustrated above and, when possible, through a face to face discussion.

However, participants were recruited through either their manager, trainer or supervisor, thus raising the question of possible negative psychological effects. According to Oliver (2004), “research respondents can feel disturbed when they are selected in circumstances where they have little choice but to take part in the research”. The ethical problem here was that although the participants volunteered, their decision to take part in the research might not have been entirely freely made. For example, the supervisees might have felt constrained to participate by the desire to please their supervisor, or by the pressure they might have felt. In these situations, as Oliver (2004) stressed, “this is an issue of moral autonomy, and the need for people to be able to take ethical decisions. [...]. It is not always possible to separate the research activity from other factors [...]. The issue of the researcher is to try and ensure that all potential respondents feel that they have the freedom to refuse to take part, if that is their wish”. In the present research, this was attained by clearly specifying the voluntary nature of the

participation in the study, for example both in the consent form and at the time when the interviews were arranged.

- Debriefing

Once the data have been collected, the researcher should provide the participant with any information to complete the understanding of the nature of research. Participants should be given the opportunity to discuss with the investigator their experience of the research, “in order to monitor any unforeseen negative effects or misconceptions” (BPS, 1993, p.10). For example, at the end of the interviews, I asked the participants if they had any comments on how it felt to be interviewed. All the participants of the three studies were offered feedback, that is, in the questionnaires there was a box to tick if they wanted any feedback, and they were all invited to attend steering group meetings and local workshops where the results were presented. Furthermore, with the participants of the third study, a debriefing session was organised. All the participants attended.

- Withdrawal

Participation to a study is always voluntary and participants should be provided with the opportunity to withdraw their consent at any time.

“In the light of experience of investigation, or as result of debriefing, the participants have the right to withdraw retrospectively any consent given and to require that their own data be destroyed” (BPS, 1993, p.11).

Participants were informed of their right to refuse to take part in the research, or withdraw at any time. In this respect, participants did not have to complete the



quantitative questionnaires, or agree to be interviewed. This possibility was made explicit and clearly written in the consent form.

- Confidentiality

Information that a participant has disclosed during an investigation is not expected to be divulged to others, unless otherwise agreed in advance.

“Participants in psychological research have a right to expect that information they provide will be treated confidentially and, if published, will not be identifiable as theirs” (BPS, 1993, p. 10).

All information obtained was kept confidential. Participants were assured that all data would be treated confidentially and no information that could lead to the identification of any individual would be revealed. Interview notes were coded so respondents could not be identified. In the present thesis, when reporting the results, I will refer to the interviewees as “T” for trainees and “S” for the supervisees, followed by the number of the interview. Participants of the third study are referred to as Participant 1, Participant 2, etc. The results obtained from the ATQ are grouped together.

- Protection of participants

Participants must be protected from potential risks, such as stress “by all appropriate measures” (PBS, 1993, p.10). Research can have some potential negative effects on participants, and cause a “sense of intrusion into one’s private world” (PBS, 1993, p.10). As Oliver (2004) suggested, this can be reduced by

clearly explaining the aim of the research and the beneficial impacts that this might have. For example, I explained that the possible beneficial effects of this research were to improve the overall training and supervision conditions for the benefit of both MHPs and service users.

Furthermore, due the nature of the content of the study, revealing personal feelings and disclosing emotions could have been a cause of distress for the participants. However, in order to avoid any unwanted reactions, the interview was carefully planned with a clinical psychologist and the focus was on both the negative and positive emotional aspects of learning. Asking about positive feelings was not merely done to serve the aims of the research, but also to help people to focus on the positive aspects of their experience. However, the distinction between interview research and counselling should be clear and if any issues had arisen, my role as a researcher would have been to suggest that the participants make contact with a suitable professional or agency, as suggested by Oliver (2004).

##### **4.7.1 Ethical Approval**

Consent to participate was attained from all involved prior to the research stage, and ethical approval was sought and given before the study began due to the sensitive nature of the experiment, by the local NHS Research Ethics Committee.

## **4.8 Data Collection**

In the section that follows, I will describe how the data were collected in each of the three studies.

### **4.8.1 Study 1**

Interviews were carried out face-to-face at the participant's work setting (usually a quiet office or room on site), or over the telephone. To facilitate the process it was ensured that all had a copy of the interview proforma during the interview, which were either sent by post or given by hand. Only the copy held by the interviewer contained the prompts. To avert potential sources of bias, the procedure was standardised as detailed below. The chronological sequence of events to which participants were exposed was as follows:

- Introduction

In introducing the research, I provided interviews with the following details: the researchers name, explanation of the research, assurances about confidentiality and the possibility to withdraw from the interview at any time. This is important in order to put the respondent at ease and make him or her feel comfortable (Smith, 1995). Furthermore, permission was asked to tape-record when the interview was conducted face to face.

- Interview (approx. 50 minutes)

The interview did not always follow the exact sequence of the schedule. Sometimes a question was asked earlier than it appeared on the interview schedule, because it followed from what the respondent had just said.

- Feedback

I explained the feedback procedures (described in section 4.7) and checked whether the participants would like feedback.

- Thank you

I thanked you the participants for taking part in the research.

To administer the Generalisation Questionnaire, I visited the trainees during their teaching sessions, with the previous agreement of their tutors. I introduced myself and explained the aims of my research and then asked them to volunteer to complete the GQ.

##### **4.8.2 Study 2**

The full questionnaire pack, containing an explanation of the study, consent form (Appendix 6), Demographic Questionnaire (Appendix 3), both the ATQ (Appendix 7) and the GQ (Appendix 8), was delivered to the trainees during the training course, either in person or through the post. They did not have to complete the pack as a requirement of the course; all those doing so completed a consent form and a sheet requiring demographic information.

##### **4.8.3 Study 3**

The DCD was kept by each of the four supervisees during the four months of the study, recording the impact of their work-related coping and their use of PSI techniques (Appendix 9).

I met the participants before the begin of the study, to explain the aim and the design of the research. Once they had agreed to take part in the study, they were asked to complete a copy of the DCD at the end of each working day for the duration of the project (four months). A senior clinical psychologist kept weekly contact with the supervisor providing the intervention. I provided the supervisor with a weekly report, where the data of the DCD were summarised and kept up to date. I met the supervisees and supervisor a couple of times throughout the duration of the study to provide feedback and comment on any issues related to the study; I also produced and emailed the participants a fortnightly "Study Newsletter", where the progress on the study were summarised. I also offered my work contact details to the participants in case they needed help or clarification. None of the participants used my contact details to seek help or clarification from me.

The intervention began for the first participant when his or her diary indicated a stable pattern of coping. In order to identify this stable pattern, the baseline data was monitored weekly with the help of a senior clinical psychologist. The intervention continued for a minimum of four to a maximum of five weekly supervision sessions. Therefore, the intervention lasted one month. It was followed by a maintenance phase, where diaries were still completed in order to allow comparison with the data with the intervention and baseline phase. The second participant then commenced so that the intervention was staggered across participants: a causal relationship between the intervention and the behaviour

would be demonstrated if each response changed when the intervention was introduced and not before (Kazdin, 2000). The effects of the intervention were inferred from score changes in the participant, while the scores remain unchanged in those supervisees who had not received the RCS. Charts showing these patterns are in the Results (Section 5.3.3)

### 4.9 Piloting

I will now explain the way in which the piloting of my instruments was conducted.

There were difficulties in finding PSI trainees or supervisees with whom to pilot the measures. I therefore decided to pilot my instruments with people with characteristics similar to the target sample (e.g. qualified mental health practitioners who were undertaking, or had recently undertaken training and clinical supervisions and who were working with service users). For example, regarding the ATQ I followed Rust and Gulombock's suggestion (1989) that

“the pilot version of a questionnaire should be completed by people who are similar to those for whom the questionnaire is intended [...] and by as many people as possible. If this is not possible, it is better to use fewer people than to omit the pilot stage” (p.158).

The DCD was based on existing instruments, however in order to facilitate its completion, some changes were made.

Further details of how the piloting was conducted for each of the instruments employed are described in the paragraphs below.

### 4.9.1 Affect in training/supervision interview

The first draft of the interview schedule was piloted with one MHP who had recently completed a training programme in clinical psychology. The interview was videotaped and two other researchers and I independently coded the qualitative questions that were included in the interview, to allow inter-rater reliability checks to be carried out. This revealed an agreement score of 93% between the three interviewers. The pilot also highlighted a number of minor adjustments that were required. These minor adjustments included changing some technical terms, for example “apply to the work-place” replaced “transferring”. In addition, some questions were re-formulated to make them easier to understand, for example Question 4 became “What do you think made it difficult to use your PSI skills with clients”, instead of “What do you think limits the success of transferring PSI training to clients”.

Following Wengrafs’ (2001) advice to pilot the interview with more than one person, a second pilot was completed with another adult learner. This was a counselling psychologist attending a post qualifying training course. The person was first interviewed by me, and then by another researcher, in order to establish inter-rater reliability of the quantitative questions. The reliability scores were calculated separately, for the first and second part of the interview. The first part

indicated 100% agreement, whilst the second indicated 50%. This was believed to be due to the technical words, for example “transfer”, rather than “applying new skills with your clients”, used in the second part of the interview. This led to further, albeit small adjustments being made, on the basis of recommendations from the interviewees and from a professional consulted. Furthermore, a 4-point scale was substituted with a 5-point scale, in order to have an intermediate rating score.

The original interview showed low agreement (below 50%) for the quantitative questions in the third part of the interview; these were not included in the final draft as they were not necessary.

Two slightly different versions of the semi-structured interview were constructed, one for the trainees and the other for the supervisees. Only a few words were changed, for example “clinical supervision” was used instead of “training”. Questions used in this final version of the interview are reported in the table below; both terminologies (training and CS supervision) are reported. Final version of the interview can be found in Appendix 4 (the trainees’ version) and 5 (the supervisees’ version).

##### **4.9.2 Affect in Training Questionnaire**

The ATQ was piloted administering it to three postgraduate students attending a course in clinical psychology. As a result of the pilot, three slightly different versions were drafted. Some changes were made to the wording of some of the



items, for example item 1 “the training will work with clients” was changed to “the training is effective with my clients”. Some items were added, for example items 9 and 10, and some changes made to the layout of the questionnaire. The final version of the questionnaires can be seen in Appendix 7.

### 4.9.3 Daily Coping Diary

The DCD was based on existing instruments. However, in order to make it easy to fill in, the sections of the instruments from which it was comprised were minimally modified.

Changes were made after meetings with the relevant manager to produce drafts 2, 3 and 4. Draft 4 was then piloted for one working week in order to check the face validity of the diary and to ensure that the participants were able to understand and complete it successfully. I then met the participants and made changes to the format, according to their suggestions, to produce draft 5, which was used for one working week and then, after further comments from the participants, a final draft 6 was produced (Appendix 9). Examples of changes made because of piloting included alterations to the wording in some questions to make it clear that the diary was referring to the stressful event that had triggered attempts at transfer; that the emotions which were asked to indicate feeling were ones that had been triggered by this event. Furthermore, it was necessary to highlight the fact that the coping strategies used to overcome this event may include those arising from outside the work setting. Lastly, an emphasis was placed on the fact that the use

of PSI methods not only included the actual implementation of them, but also explicit planning and explanations to their clients. The participants accepted this final version of the DCD, indicating its face validity.

### **4.10 Data analysis**

In the following paragraphs, I will introduce how data were analysed on each for three studies.

#### **4.10.1 Study 1**

The interview scheduled contained both qualitative and quantitative questions. These were analysed using the methods described below.

##### ***4.10.1.1 Content analysis***

The content analysis procedure was derived from several texts (Kazdin 2002; Wengrafs, 2001; 1995; Smith, J. 1995), which provided a consensus account of the “correct” or conventional steps in a content analysis of the present kind. However, as this continues to be an emerging field, it is recognised that alternative procedures are being developed. The assumption is that the analyst is interested in learning something about the respondent’s psychological world (Smith, 1995). Therefore, content analysis was especially appropriate for the study of a new area, emotions in training. The method used in the present study was an inductive content analysis, using methods as outlined in Smith (1995). This involved:

1. Independent reading of transcripts (interview record forms) making notes, and taking notes of emerging themes.
2. Listing emerging first order themes (meaning units) and looking for connections between them (clusters, to form master concepts).
3. Meeting/discussing/agreeing with co-researcher/s to calculate the reliability of the first order themes, and to agree categories.
4. Meeting again to organise data groups into categories (second, third and fourth order themes).

##### ***4.10.1.2 Trustworthiness of the content analysis***

A colleague and I independently rated the first three interviews to determine the trustworthiness of the analysis. Agreement between us was very high for the emerging first order themes (90%). Once the analysis had been completed, a senior clinical psychologist not involved in the first stage was consulted, in order to review the decisions made in the analysis, and to further enhance the trustworthiness of the procedure.

##### ***4.10.1.3 Analysis of the quantitative questions and the GQ***

A number of quantitative questions were included in the interview for direct comparison with the findings of the qualitative aspect. The means and standard deviations were calculated for such items. Data from the GQ were also analysed using means and standard deviations. In order to verify possible relationships between transfer and the trainees' views, correlations were computed between these quantitative questions and the data from the GQ. Data were computed using SPSS version 11.

### 4.10.2 Study 2

In order to validate the psychometric properties of the ATQ, an item analysis was conducted using the Pearson's product moment correlation co-efficient (Pearson's-r). This analysis may support the associations between the variables of the ATQ. An explorative factor analysis was then used to verify whether the different items could be placed into a scale. Reliability tests such as Cronbach's alpha for internal reliability and test re-test reliability were used to validate the psychometric properties of the scale.

Descriptive statistics (means and standard deviations) were computed. Correlations between the ATQ and GQ (the simplified questionnaire allowed this where previously only descriptive statistics were used) helped to identify any possible relationships between training, transfer and emotions. The data was analysed using the SPSS (Statistical Package for the Social Sciences), version 11.

### 4.10.3 Study 3

The means, standard deviations and frequencies were calculated for each section of the DCD. Section B of the instrument required participants to circle a number from 1 to 10 to indicate how often they used a particular coping strategy. In terms of interpreting the scores, some coping strategies have been identified by the literature as being "problem focused coping" (direct action, situation redefinition, seeking social support and religion), and some as "emotion focused coping" (distraction, catharsis, acceptance and relaxation) (Carver *et al.*, 1989; Moos, 1997).

Visual inspection of graphs is the primary method of data evaluation for single case research (Kazdin, 1982). The raw data were graphed and visually inspected by myself, looking at “peaks” (increases) and “troughs” (decreases). The possibility of explaining patterns of behaviours (and in particular the mediating role of coping) using the Lazarus model was investigated by comparison of the relevant lines before, during and after the administration of the intervention. Simultaneous peaks in two lines indicate a possible association.

Visual inspection techniques were supported by an auto-regression analysis (Chatfield, 1996). This was performed with the support of a professional statistician working in Durham University. This kind of analysis is commonly used for time series analysis. A time series is a set of observations obtained by measuring a variable regularly over a period of time. In a time series analysis, a variable, for example a coping strategy, is observed at regular intervals over a certain length of time. There are two main reasons for using an auto-regression analysis. First of all, it allows forecasting of future values of the series. The parameters of the model that explained the past values may also predict whether and how much the next few values will decrease or increase. For example, it might predict that coping strategies tend to vary in connection with certain events.

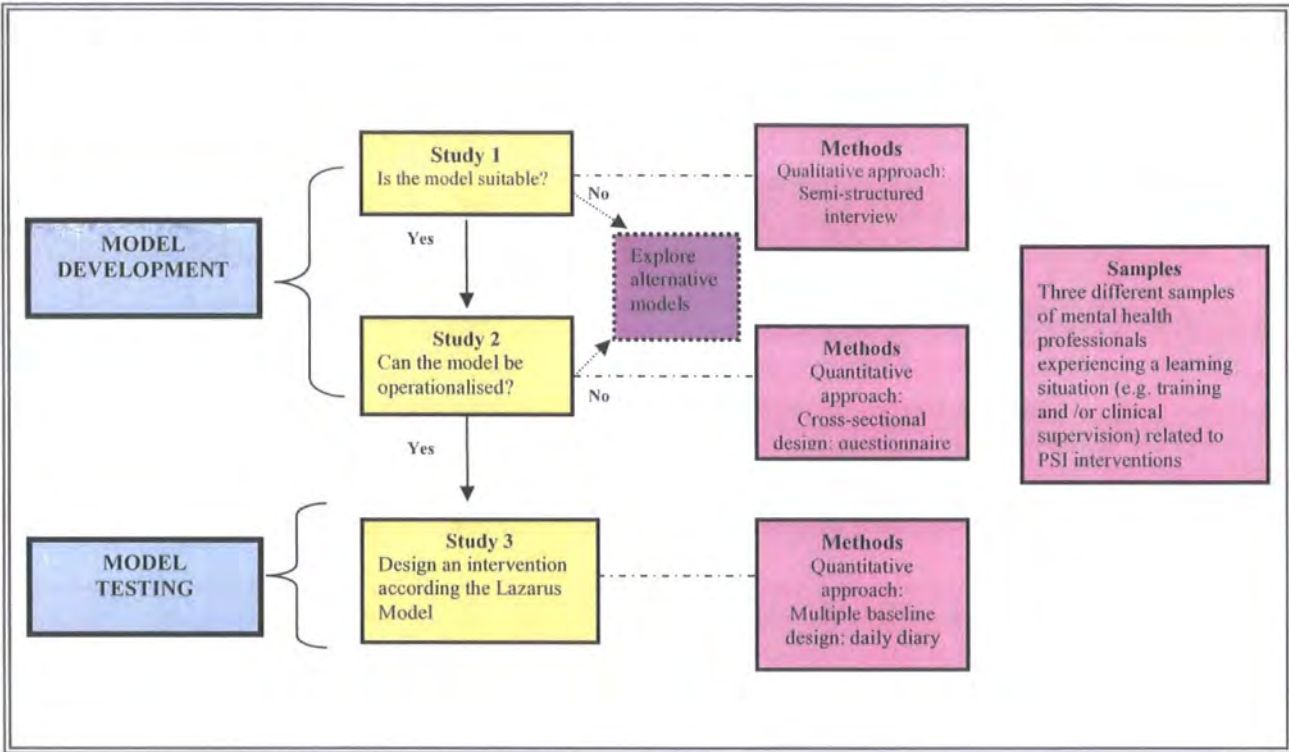
Another important reason for using an auto-regression analysis is to evaluate the effect of an event (RCS) that intervenes and possibly changes the normal behaviour of a series of data. The aim is to see whether this event, or intervention,

had an impact on the series of data. It is important to stress that in the case of the present study, a standard regression analysis might not be valid because the variables represent a time series. This is because most time series have trends, for example the increase or decrease of scores, and any of the “trending” series will correlate simply because of the trends, regardless of whether they are related or not. Auto-regression allows removal of the auto-correlation inherent in many time series and determines significant relationships between dependent and independent variables (SPSS trends, 2004).

### **4.11 Conclusions**

This chapter has introduced the three research objectives and the two hypotheses of the thesis, and the qualitative and quantitative methods employed to achieve these objects. The work undertaken to achieve the objectives has been referred for convenience as Study 1, 2 and 3 respectively. The Chapter has also described in detail the instruments, how participants were sampled, as well as the ethical considerations I faced for the whole research. The diagram below shows the overall research design and is a representation of how the three studies fit together. Chapter 5 will now present the results of the present investigation.

Figure 4-1 Diagrammatic representation of the three studies



5 RESULTS

In this chapter, I present the results of my investigation. Each study is presented in a different section.

5.1 Study 1

In this section of the chapter, I will present the results of the demographic questionnaire, the semi-structured interview that was administered to all the participants, and of the Generalisation Questionnaire that was administered only to a part of the sample. I will start with a description of the characteristics of the sample.

5.1.1 Sample

The sample consisted of 21 health and social care professionals. Eleven of them were attending a training course; the remaining participants comprised ten supervisees. The characteristics of the sample are reported in Table 5-1, while Table 5-2 provides some details on the supervision sessions.

Table 5-1 Demographic characteristics of trainees and supervisees

	N	Gender	Age	Professional Occupation		Time spent in present post
Trainees	11	(F:M= 8:3)	M=39 SD=8.64	SW	3	M=5.4 SD=4.9
				P	1	
				OT	3	
				CC	3	
				CPN	1	
Supervisee	10	(F: M = 8: 2)	M=36.7 SD=8.27	SW	1	M=5.9 SD=4.3
				OT	1	
				CPN	10	
Total	21					

Key: SW= Social Worker; P=Psychiatrist; OT=Occupational Therapist; CC=Care-Coordinator; CPN=Community Psychiatric Nurse



Table 5-2 Characteristics of supervision sessions per number of supervisees

Frequency of sessions	Supervisees (N)	Length of sessions	Supervisees (N)	Location of sessions	Supervisees (N)
Monthly	9	≥ 60 min	8	Workplace	9
Every 6 weeks	1	45-60 min	2	Other*	1

\* Not specified

5.1.2 Inductive content analysis

I will now report the findings of the interviews.

From the inductive content analysis three 4th order themes emerged: ‘Learning and Transfer’, ‘Relational aspects of Learning and Transfer’ and ‘Emotions in Learning and Transfer’, with subsequent sub-themes. I will now introduce each of the 4th themes and, in order to distinguish the trainees’ experience from that of the supervisees, they will be summarised separately.

5.1.3 Learning and transfer

Within the learning and transfer section, three third order themes were included: experience of learning, learning barriers and experience of applying and then eight second order themes, as illustrated in the table below.

Table 5-3 Extract from content analysis (learning and transfer section)

4 <sup>TH</sup> order themes	3 <sup>RD</sup> order themes	2 <sup>ND</sup> order themes
Learning and transfer	Experience of learning	a) Trainer/supervisor characteristics (Positive and Negative)
		b) Reactions to training/supervision
		c) Structure of the course/supervision (Positive and Negative aspects)
		d) Attitudes
	Learning Barriers	e) Physical environment
		f) Time & work overload
	Experience of applying	g) Experiences with clients
		h) Use of skills

5.1.3.1 Experience of learning

The respondents’ views on ‘experience of learning’ have been divided into ‘trainer/supervisor characteristics (positive and negative)’, ‘structure of the course/supervision (positive and negative aspects)’ and finally ‘attitudes to learning and transfer’. These are now elaborated:

a) Trainer’s characteristics

More than half of the respondents commented on positive trainer characteristics, for example:

‘The course leaders were very experienced, they provided very good examples; they were colourful characters’ (trainee (t) 1, question (q) 5)

‘Trainers were very helpful and accessible’ (t8, q5)

These two examples show how the personal characteristics of the trainer ('helpful' and 'accessible', 'colourful') and teaching abilities ('very experienced', 'good examples') were seen as relevant by the interviewees.

In relation to the supervision situation, the positive characteristics were more focused on the role of the supervisor as a facilitator, as can be seen from the following examples:

'Supervisor was good at helping to reflect on practice' (supervisee (s) 2, question (q) 1)

'My supervisor encourages me to say more about what I am good at' (s6, q6).

The supervisees also commented on the fact that the supervision was strongly connected to practice and gave the opportunity to reflect on clinical experience:

'The supervisor was good to help to reflect on practice' (s1, q6).

'[Clinical supervision] gives me time to reflect, it is essential for practitioners' (s4, q1)

'It's a place to reflect on what I do clinically. It's a place to 'bla', to take things out of the chest' (s, 1, q1)

From these comments, it can be seen how, in some aspects, CS is different from classroom training. On the one hand, supervision is usually more personal, private issues are sometimes covered and there is a stronger involvement of personal feelings.

### b) Reactions to training/supervision

More than half of the trainees made comments relating to their general reactions to the training course. In general, the respondents seemed quite happy about the course they were attending and gave the impression that training is a valuable aspect of a clinician's job. For example, these trainees found the course 'enjoyable' (t1, q1), 'useful' (t1, t3, t5, q1) and 'well organised' (t1, q1); and others felt that 'there was lots of info' (t7, q1).

Only one respondent expressed slight disappointment, saying that:

'the course was challenging, but most of the times we went over the same things' (t4, q1).

Regarding the supervisees, almost all of them were happy with the quality of the supervision they received, which can be seen from the comments below:

'I am receiving high quality, consistent supervision' (s1, q3)

Some of the participants felt that CS was both 'a really positive experience' and 'a necessary part of the job' (s8, q1), placing great emphasis on the importance of receiving feedback on their work with clients.

### c) Structure of the course/supervision

Further comments related to the structure of the course and the supervision; in particular the positive and negative structure of each. For example, the course participants came from different professional backgrounds, with one trainee commenting on the technical

nature of the language used by the tutors:

‘Too many medical terms were used’ (t9, q10)

However, the same person showed disappointment with other aspects of the course, expressing his/her general feeling of dissatisfaction:

‘The framework was very rigid, wrong structure of the course’ and ‘Too much information’ (t9, q4).

He/she also commented on the expectations of the tutors:

‘Expectation unrealistic, mismatch between reality and expectation’ (t9, q2).

However, he/she was the only person who commented negatively on this aspect of the course, and as I will illustrate later in this chapter, the same interviewee had strong negative feelings towards one particular tutor. A few trainees (less than half) commented on the positive aspects of the structure of the training, saying that it was appropriate, and that the course was well organised, useful and practical.

By contrast, almost all of the supervisees made positive comments on the structure of clinical supervision. This is probably because clinical supervision occurs one-to-one or in small groups, and so is usually adjusted to the individual’s needs.

In particular, those receiving the clinical supervision focused both on the importance of agenda setting and a flexible structure:

‘The structure of each session is led by what I wanted to talk, very open, issues discussed were those that I brought.’ (s2, q1)

Nevertheless, two supervisees were disappointed with the fact that managerial issues were covered during the sessions, especially at a high level.

‘I would like to get more clinical supervision, although I am a high grade’ (s1, q10)

#### d) Attitudes

Below are presented some quotations from the interview transcript that show the attitude that the respondents had towards training and supervision. In general, the interviewees saw learning new skills as an important part of their profession:

‘Learning in general is always a good thing to do’

‘My attitude was always that it (supervision) was a problem solving session; it gives me a wider picture to look at things instead of being blinkered.’ (s3, q1)

### 5.1.3.2 *Learning Barriers*

Sometimes respondents reported impediments to their learning, which have been classified as 'physical environment' and 'time and work Overload'.

#### e) Physical environment

The people who attended the training course were all in agreement about the poor quality of the venue:

'the room was smelly, noisy when fan was on, not conducive to learning', (t8, q3)

with some people even asserting that:

'The physical environment was not conducive to learning; it was cramped, hot, there were uncomfortable seats. It felt like a torture, I was falling asleep, affected concentration badly!' (t9, q1).

Although the supervisees were in their more comfortable environments, one respondent would have preferred to receive supervision in his/her own office, rather than in the supervisor's:

'It feels like I am called to see my teacher, quite territorial, as we are always in supervisor's office. It also would be nice to get away from the workplace, the

environment can be distracting: we have got thin walls and the supervisor's office is next to reception'. (s 9, q3)

Only one other person complained about the location, in this case because of continuous interruptions:

'Supervision sessions occur in a small office, and we are often disturbed by telephone calls, even though we tell in reception that we are in supervision. Also desks between you and the supervisor create a physical barrier: general environment is appalling for everyone, can add to stress'. (s 5, q 4)

#### f) Time and work overload

Most of the people attending the course referred to time and work overload as being big learning barriers; most respondents reported they could not find enough time to do their assignments, and some of them complained about the time-scale of the course, in particular:

'The time factor was a big problem: planning homework and managing the caseload was difficult. There was lots of work to do in ten days'

However, almost all of the supervisees felt they did not have enough time to dedicate to their clients. In particular, two supervisees strongly complained about the amount of time spent on bureaucracy, expressing their anger thus:



‘I have got lots of computer work as a clinician, I haven’t got the time, I am not a secretary. [...] It takes my time away from clients, disgustingly so. I feel I am policing people and being policed, rather than being a social worker’ (s 7, q 4).

‘In the care management structure it is difficult to apply skills. Paperwork and computer work take the priority’ (s8, q5).

### **5.1.3.3 *Experience of applying***

The comments related to the experience of applying referred to either the experience with clients or with the application of skills.

#### **g) Experiences with clients**

Most of the trainees found it difficult to apply the new skills with their clients; a few of them referred to difficulties in finding a suitable client:

‘I could apply PSI with only one of my clients, because I am working in an elderly service’ (t1, q4).

One trainee reported that he/she found it hard to restructure his/her way of working:

‘I found it hard to work with clients. With old clients you have an established way to work’ (t6, q4).

The supervisees made few comments on their general experience of working with clients. However, most of them complained about the number of clients they had:

‘Caseload is too high; clients have different demands: some take up more than others’.  
(s8, q4)

‘I constantly overwork, I have a large caseload; it gets difficult to do something therapeutically focused and evaluate it’ (s8, q4)

#### h) Use of skills

In general, the trainees were not entirely satisfied with their application of skills in the workplace. However, a few of them admitted that some progress had been made:

‘PSI gives me instructions to apply [skills with clients]; I didn’t change my style, I am using PSI as a guidance, asking more direct questions; it gives me a more structured framework, I have more dialogue with my clients. I managed to use most of the tools, I tested them out’ (t3, q2).

‘I improved through the course; I have used a restricted number of techniques. Maybe I picked up the wrong patient. Doing drug assessment helped, got to know the client more’ (t10 q2).

One particular trainee stated that:

‘Applying it [PSI] in practice was too artificial. Too much information, too rigid to get through clients’ (t9, q4).

However, the same trainee explained how this difficult situation was handled, explaining that ‘ sharing experiences with colleagues was helpful’.

Supervisees did not make many comments about the use of their PSI skills. However, one supervisee commented that:

‘The application of skills can become the bottom of the pile. In the care management structure it can be difficult to apply any skills: paper work and computer skills take the priority’ (s8, q4)

5.1.4 Relational aspects of learning and transfer

Within the relational aspects of learning and transfer section two third order themes were included: support and emotional reactions to trainer/supervisor, then four second order themes were identified, as illustrated in the table below.

Table 5-4 Extract from content analysis (relational aspect of learning and transfer)

4th order themes	3rd order themes	2nd order themes
Relational aspects of learning and transfer	Support	i) In the course/during supervision
		j) In the workplace
	Emotional Reactions to trainer and supervisor	k) Positive
		l) Negative

#### 5.1.4.1 *Support*

The respondents' comments related to 'support during the course/supervision' and 'emotional reactions to trainer/supervisor'. Detailed explanations are given below.

##### i) Support during the course/supervision

More than half of the trainees felt that they were receiving support from some people on the course. More specifically, four people felt that they had the support of fellow trainees, while only two felt that they received support from the course tutors.

Some respondents found it very useful to share ideas with the other people attending the course:

'There were many people to talk to and compare findings, that was very helpful' (t10, q2).

Sometimes talking to the other trainees was useful in boosting their own motivation:

'Peer support was very important, particularly chatting to others who had similar difficulties; important to enhance your own motivation' (t7, q5).

The possibility of talking to others who are experiencing the same situation is what makes the difference between the support in training and in supervision, as I will illustrate later.

More than half of the supervisees felt they had the support of both their supervisor and work colleagues. In particular, one supervisee mentioned on four different occasions that he/she was very well supported:

‘Supervision is generally very supportive and quite encouraging’ (s10 q5)

and:

‘it’s important to receive support from someone with higher experience and knowledge base’ (s10, q1).

In a few instances, supervisees referred to the supervisor’s support received and how it was often linked to perceived empathy. For example, one interviewee was describing a particular situation where a client had been arrested and how he/she felt particularly affected by this case. This interviewee reported being very upset and the supervisor’s contribution was especially valuable in understanding how he/she felt and had been affected from an emotional point of view.

‘I had thrown up, shared with supervisor, [...]. Empathy was there, supervisor felt the same as I did, he reassured me that I was not unique in what I was feeling’ (s5, q8).

On one occasion, a supervisee experienced a situation where he/she had been helped and supported, although the problem did not strictly relate to clinical practice:

‘I experienced some difficulties with a member of staff. I talked with my supervisor about that, and received great support’ (s7, q8).

j) Support in the workplace

The comments related to the support received at work, referred either to colleagues or to managers. Comments about colleagues were usually positive, and most trainees found peer support to be a good strategy, as for example:

‘I had good support from my team; there are great colleagues in Mental Health!’ (t6, q1)

Although most of the trainees felt they had the support of their managers:

‘Senior management was a key element’ (t6, q5).

and felt

‘driven from the top’ (t6, q5).

one trainee commented that there was:

‘No supportive environment, especially at managerial level’ (t4, q4).

In total, half of the supervisees felt supported by managers and other colleagues, with only one respondent claiming the ‘need of extra support’ (s4, q4). This may be why this interviewee also complained about the lack of a budget, the amount of work demands, and the high expectations of senior colleagues.

People felt they were receiving support both for work related issues and for personal concerns, as illustrated in the examples below.

‘People at work are very supportive and give me ideas’ (s3, q4).

‘The whole team helps to support each other; lots of feedback and support from my colleagues (s6, q5).

‘I received support during difficult times from team, when both my mother and my grandmother died’ (s6, q8).

#### ***5.1.4.2 Emotional reactions to trainer/supervisor***

The emotional reactions to trainer/supervisor, have been classified into positive and negative, according to emotions expressed by trainees and supervisees.

##### **k) Positive reactions to trainer/supervisor**

On the positive side, some people were very impressed with the enthusiasm of the tutor, with one respondent stating that:

‘Passionate tutor did pass [his enthusiasm] this on to me’ (t10, q1)

and another participant said that:

‘I enjoyed the way sessions were run’ (t3, q1)

and

‘Trainers generated enthusiasm with their teaching styles’ (t3, q1)

Almost all the supervisees felt reassured and strongly supported by their supervisor:

‘I have received emotionally positive support from my supervisor’ (s1, q8)

‘My supervisor gives me positive feedback, allowing confidence to keep going’ (s 7, q6).

One supervisee referred to a situation that had affected them, where a client had committed suicide. The same person also mentioned an occasion when he/she had experienced personal problems, and the supervisor was very supportive:

‘It was a tragedy and my supervisor suddenly become more available in a very supportive functional way. I also had a problem in my personal life. She was informally very supportive and very perceptive and a very caring person’ (s7, q9).

#### 1) Negative emotional reactions to trainer/supervisor

Although people commented positively on the trainer’s skills, a few trainees reacted



emotionally and very strongly to some of the attitudes of one particular trainer. Specifically, one trainee felt distressed and that he/she was not respected:

‘Trainer was distressful and oppressive: inhibited any challenges’ (t9, q1)

‘Felt frustrated and irritated as your workload was not considered, trainer was patronising all the time’ (t9, q1).

Another respondent referred more precisely to the effects that this tutor’s behaviour had on his learning:

‘Tutor made me feel angry, his remarks were distracting’ (t10, q8).

Only one supervisee reported negative emotional reactions to their supervisor, mainly connected to the fact that the supervisor had previously been their the manager:

‘Sometimes I felt uncomfortable, supervisor had been my manager previously, I didn’t want to come across as an idiot’ (s 1, q6)

**5.1.4.3 Emotions in learning and transfer**  
Within the emotional aspects of learning and transfer section, two third order themes were included: emotional reactions to learning and emotional reactions to transfer; then four 2nd order themes were identified, as illustrated in the table below.

Table 5-5 Extract from content analysis (emotions in learning and transfer)

4th order themes	3rd order themes	2nd order themes
Emotions in learning and transfer	Emotional Reactions to Training and Supervision	o) Positive
		p) Negative
	Emotional Reactions to Transfer	q) Positive
		r) Negative

5.1.5 Emotional reactions to training and supervision

From the content analysis of the interviews, it emerged that trainees and supervisees commented on the emotional reactions provoked by both training and supervision.

o) Positive emotional reactions to training and supervision

Specifically, more than half of the trainees experienced positive feelings connected to their training. For example, it was common to experience feelings of enhanced confidence, as can be seen from the comment below:

‘[Before] I learnt a lot through experience, but had no guidance or reinforcement; this training gives me confidence to go further in areas I was not confident’ (t5, q1).

Motivation was mentioned by a couple of people, while other respondents referred to ‘general positive feelings’ (t8, q5). One trainee felt ‘lucky to be on this course’ (t10, q1). Another person remarked that working in a small group, during the teaching session, made her feel ‘safe’ (t3, q3). This may be because people feel that they can make

mistakes and not be judged when they are working in small groups. Finally, one respondent felt 'respected' (t6, q8), as nobody was forced to attend the course.

There were also some positive reactions connected to the role-playing exercise. One trainee commented:

'Fully enjoyed the role-play: felt safe, reassured and enthusiastic' (t10, q8).

Almost all the supervisees reported an enhanced sense of confidence connected with their supervision sessions:

'Clinical Supervision helps, it's good to receive positive feedback , allowing my confidence to keep going' (s6, q6).

'I am feeling listened to, gives me to confidence to move on' (s6, q5).

#### p) Negative emotional reactions to training and supervision

However, half of the trainees also reported feelings of anger and frustration. In particular, one trainee reported his frustration on two different occasions, in connection to the structure of the course:

' I found it frustrating practising all the time. Time could have been better used' (t11, q3).

and

‘Impatient, I wanted to know what was going to happen next and what the interventions would be’ (t11, q3).

Two participants experienced some anxiety, in connection with the amount of work that the course entailed:

‘I felt anxious not to pick up deadlines’ (t5, q3).

The trainees also commented on the emotions provoked by the role-playing exercises. It was reported that the role-play caused many different emotions, but whilst the evoked emotions were sometimes negative (anxiety, embarrassment), these were not intense enough to interfere with the exercise. For example, one respondent said that:

‘Role-playing was tedious. The first time I felt anxious, but not enough to disrupt’ (t11, q5).

Half of the supervisees expressed negative emotions in relation to their CS sessions:

‘Sometimes clinical supervision can be frustrating, it can be very hard’ (s6, q1)

Two supervisees expressed other negative emotions. However, they also manifested a sense of awareness of their feelings and in some cases described ways in which to

overcome these negative emotions. For example, one respondent commented on the fact that he/she received mostly managerial supervision:

‘When you are higher grade you get less clinical and more managerial supervision. I feel more isolated, as you are supposed to be independent. I have searched peer supervision and attended a forum’ (s1, q3).

The other respondent described his/her strategy for overcoming anxiety:

‘I do feel anxiety when I wonder whether I am doing the right thing, but generally I get general positive emotions from setting my own agenda’ (s3, q8).

One participant expressed a dislike for group sessions:

‘I attend some group sessions, [...] but I prefer one to one. It’s sometimes uncomfortable: you always get someone who talks too much and vice versa’ (s3, q3).

A few supervisees also described how sometimes clinical sessions can cause anxiety or distress, but then dealing with a specific problem makes them feel better:

‘Anxiety was very significant emotionally, as was very nervous before and during sessions at first. Ironical, because I felt relieved when finished’ (s2, q8).

### 5.1.5.1 *Emotions in transfer of learning*

The section below clearly shows that emotions are reported during the transfer of learning. The trainees mentioned many different emotions (mainly negative).

#### q) Positive emotions in transfer

There were only a few examples of trainees experiencing positive feelings during transfer. In particular, one person stated how a good workplace environment is important for the transfer of training:

‘PSI in supervision was great. Keeps me motivated and exited about it, lots of positive feelings’ (t10, q6).

Supervisees did not generally mention that they experienced positive emotions when working with clients. Some reported feeling proud when they had successfully worked with clients. One particular respondent was quite satisfied with the fact that he/she was using PSI skills and keeping his/her professional identity:

‘PSI helped me to do an excellent job. It’s new stuff, and first I had this feeling: ‘I can’t do that’. Now I feel very proud. I am working on a team and I am trying to maintain my role identity’ (s. 1, q8).

#### r) Negative emotions in transfer

However, nearly all the trainees, and some of them more than once, mentioned some negative feelings connected to the transfer of training. A few of them related to ‘disappointment’ about the work environment:

‘I felt disappointed because my workplace doesn’t allow me to apply PSI’ (t4, q2)

another complained about the lack of opportunities to use PSI skills:

‘Disappointed, I would have liked more opportunities to apply the skills’ (t1, q9).

When given the opportunities to use their skills with clients, two respondents felt ‘unfamiliar’ with these new skills. Sometimes a particular technique made them feel uneasy, probably because of the lack of confidence in using new skills, as can be seen below.

‘I felt uncomfortable when asking some of the questions to the clients, for example, when using the KGV [standardised clinical assessment]. I didn’t know how the client would react, I felt intrusive’ (t1, q9)

Frustration was mentioned a few times by different respondents, and was evoked by different situations. On one occasion, the person highlighted the difficulties of working with a heterogeneous caseload:

‘Frustration in applying [the skills] with different clients with different diagnoses, pushing in different directions’ (t2, q10).

In other cases, negative emotions were evoked by the particular situation of the client, a further factor in the transfer situation:

‘Client was not able to pay his rent, had to move from his house. You can’t do anything, you just feel powerless’ (t6, q9).

Negative emotions were more common amongst the supervisees too. Some described feelings of frustration, anxiety and stress. Sometimes these feelings were connected with mistakes made with a client, or with the fact that, due to time constrictions, they could not work long enough with a particular client. For example:

‘Forgetting to ask something to a client makes me frustrated. For example, with a client I was meant to ask about suicide and then I forgot. That made me feel stressed and frustrated’ (s.3, q9).

‘I get very frustrated when I don’t have the time to transfer what we discussed in supervision and not be able to put ideas into place in the way I would like them to be’ (s9, q9).

#### **5.1.6 Summary**

In conclusion, below are the key points of this analysis.

The respondents made some ‘non-emotional’, general comments regarding the training and supervision, and the trainer and supervisors. The majority saw both the trainer and supervisors as competent and skilful. They also commented positively on the quality of



the training and supervision sessions. Occasionally, there was some disappointment with the content being repetitive and one trainee consistently complained about the quality of teaching, about the trainer's behaviour and the structure of the course. A few supervisees expressed discontent regarding having to cover managerial issues during their supervision sessions. Overall, the respondents showed a positive attitude towards learning. However, some learning barriers were identified: trainees commented on the poor quality of the venue, which was noisy and hot. Supervisees received supervision in more comfortable physical environments, although one supervisee would have preferred to have received the supervision in his/her own office and another complained about the continual interruptions due to phone calls. The trainees identified lack of time as another barrier to learning.

From the interviews conducted, it emerged that both trainees and supervisees considered the relational aspect of their training and supervision as very important. In the case of the trainees, this was particularly expressed in the form of support from fellow trainees and from colleagues at work. Furthermore, there were some strong emotional reactions towards the trainer, both positive and negative. For some, the trainer generated enthusiasm, but for others, feelings of anger and anxiety. Only one respondent expressed disappointment with support at a managerial level. The supervisees all seemed to be satisfied with the relationship they had with their supervisor, all feeling strongly supported and understood. Compared to the trainees' group, they were less happy with the relationships they had with other colleagues.

Finally, the respondents described their emotional experiences widely when learning and when transferring the new skills to practice. The trainees felt motivated to learn and more confident, however they also experienced frustration and anxiety. The experience of transferring skills to their work with clients was, on the whole emotionally difficult, with trainees expressing feelings of disappointment, uneasiness, frustration and powerlessness. Supervisees reported an enhanced sense of confidence linked to CS; although half of the supervisees expressed negative emotions, they manifested a certain level of awareness and described ways of coping with these negative feelings. In certain cases, a negative feeling was followed by a sense of relief. Some supervisees felt proud when working with clients, but expressed similar negative feelings to those experienced by trainees (frustration, anxiety and stress), usually connected with mistakes made with clients or to the lack of time to work as planned. When learning, almost all the supervisees felt an enhanced sense of confidence. When working with clients, they mentioned few positive emotions, although some referred to being proud and satisfied they also described some frustration and anxiety. When working with clients, most of the supervisees expressed negative emotions, such as feelings of frustration, anxiety and stress.

#### **5.1.7 Training and the experience of transfer**

Findings from the scaled questions given in the interviews are presented below, using means and standard deviations.

##### **5.1.7.1 *Attitudes towards training/supervision and transfer***

When asked to rate their attitudes towards training and supervision ('How would you rate your experience of training/supervision?'), the respondents seemed to be quite favourable. However, when the trainees' group rated the experience of transfer ('How

would you rate the general success of applying the PSI training to the workplace?’) they manifested a more negative attitude (M 2.82), however there was a lot of variability indicated by the value of the standard deviation (SD 1.08). The attitudes towards training/supervision of trainees and supervisees did not differ significantly.

**Table 5-6 Questions 1 and 2: attitudes toward the success of training/supervision in general**  
(1=highly negative, 5=highly positive)

ATTITUDES	Mean	SD
Q1. Attitudes toward the supervision/training		
Trainees	4.64	0.67
Supervisees	4.64	0.5
Q2. Attitudes toward the experience of transfer of skills		
Trainees	2.82	1.08
Supervisees	4.5	0.70

**5.1.7.2 Barriers and boosters to training/supervision and transfer**

Respondents were also asked to report any possible barriers to both training and supervision (Was there anything that limited your learning experience?) and the transfer situation (What do you think made it difficult to use the PSI training skills with your clients?) They were asked to rate the relevance of the barrier indicated (To what extent did this limit the success of your training/supervision? and To what extent did this limit the success of using the skills you learnt with your clients?).

Although the respondents listed a series of barriers to both training/supervision and transfer, the quantitative data suggest these had a limited negative impact on learning. The average for the trainees was 2.5 (SD 0.97) and for the supervisees the average was 2.1 (SD 1.38), indicating a slight limitation to the success of transfer. However, there was a discrete amount of variability amongst the participants, as described by the standard deviation value. Regarding the transfer situation, again the data show a moderate impact

of barriers to the work with clients, with an average score of 3 for the trainees and 3.1 for the supervisees, indicating a ‘moderate’ barrier in both cases. The amount of variability amongst participants was high in this case too, with standard deviations scores of 1.38 for the trainees and 1.47 for the supervisees.

**Table 5-7 Question 3 and 4: barriers to training/supervision and in transfer**  
(1=not at all 5=very significantly limited)

Attitudes	Mean	SD
Q3. Significance of barriers in session		
Trainees	2.5	0.97
Supervisees	2.1	1.38
Q4. Significance of barriers in transfer		
Trainees	3	1
Supervisees	3.1	1.47

The participants were also asked to indicate any possible booster to training and supervision (What do you think contributed to the success of the training programme/supervision session?). They were asked to rate the relevance of the booster indicated (To what extent did this contribute to the success of your training/supervision?).

The results of the ratings suggest that the facilitators reported by the interviewees were perceived as having contributed significantly to the success of both training and supervision.

**Table 5-8 Question 5 and 6: descriptive statistics**  
(1=not at all 5=very significantly contributed)

Attitudes	Mean	SD
Q.5 Significance of boosters in session		
Trainees	4	0.89
Supervisees	4.7	0.51
Q6. Significance of booster in transfer		
Trainees	3.5	0.71
Supervisees	4.7	0.67

### 5.1.8 The Generalisation Questionnaire

In order to check any possible relationship amongst the reported transfer rates and the data obtained from the semi-structured interview, the scores for the quantitative questions in the interview were correlated with the scores obtained in the GQ. The results of this can be seen in table below.

**Table 5-9 Correlations between the generalisation questionnaire and interview items**

	1	2	3	4	5	6	7
1 GQ							
2 GQ	.417						
3 GQ	.246	.348	-				
4 Int. rating	.596*	-.269	-.234	-			
5. Int. rating	-.452	-.234	.111	-.712*	-		
6. Int. rating	.334	.471	-.327	.264	-.437	-	
7. Int. rating	.801*	.679*	.877**	.067	-.336	.320	-

Key: GQ. = generalisation questionnaire item ; 1 GQ. Clinical effectiveness; 2 GQ Number of clients; 3 Gen. GQ ExperienceInt. rating = interview rating; 4 Int. rating General success of applying; 5. Int. rating Amount barriers limited transfer; 6. Int. rating Felt able to transfer 7. Int. rating Amount boosters contributed to transfer

\* = Significant at 5% level \*\* = Significant at 1% level

Not surprisingly, there are significant correlations between ‘clinical effectiveness’ (GQ item: How much effect did the training have on your clients?) and ‘the general success of applying PSI’ rated by the respondents in the semi-structured interview. These two items measure similar aspects. ‘Boosters to transfer training skills’ was positively correlated with all three items of the GQ, thus indicating that when boosters are perceived to have an impact on transfer, and participants rate high scores, then the scores of ‘clinical effectiveness’, ‘number of clients’ and ‘experience’ are also rated higher. Finally, when participants perceived that the reported barriers had an impact on their transfer, the ‘general success of applying’ was rated with lower scores.

In conclusion, regarding the correlations, only four of the items correlated significantly with the generalisation variable; it is possible that many other items would have become significant if a larger sample size would have been used.

### 5.1.9 Summary

From the results of the content analysis, it emerged that the three variables (cognitive, motivational and relational,) of the Lazarus model (1991, 2000) were present in the learning situation. Participants expressed a number of emotions, often the results of relationships with colleagues, the trainers, or even the physical environment where the learning took place. In some cases, they were able to use some sort of cognitive mechanism to cope with the negative attitude of their trainer, and the motivational variable acted as a booster in difficult situations. The correlations between the quantitative questions in the interview and the GQ, allowed me to conduct a preliminary

analysis of the links between emotions and transfer. The results of this preliminary analysis highlighted links between transfer and some of the perceived barriers and boosters. However, the results of this first study are based on qualitative data, that, although difficult to generalise from, are useful to describe and explore a new phenomenon. Furthermore, the correlational analysis was based upon 11 participants only. I decided to operationalise the Lazarus model in order to generalise the results and to prove that this is a good model to explain emotions in learning and transfer.

## 5.2 Study 2

This present section is divided into two parts. In the first part, I will assess the psychometric properties of the instrument, the ATQ, as recommended by the relevant literature. In the second part of the chapter, I will investigate any possible relationships within the emotions experienced in training and transfer, and look at possible influences.

Psychological scales designed to measure human behaviour, attitudes and emotions must have good psychometric attributes. Questions should be considered as measures of a particular variable, which is why the reliability and validity of a scale should be assessed. Oppenheim (1992) argued that 'reliability and validity are two properties which constitute the essence of data generation of any kind' (p.59). Reliability is the consistency of the measurement, or the degree to which an instrument measures the same way each time it is used under the same condition with the same subjects. Validity is how close what is being measured in a questionnaire is to what is intended to be measured in the

theory, in other words, whether an item of a questionnaire measures what it is supposed to measure (Kline, 1998).

Once the reliability and validity of a scale have been checked, there are two further steps to assess the properties of a questionnaire. The first step is to conduct an item analysis in order to eliminate unsatisfactory items (Nunnally & Bernstein, 1994). The next step is factor analysis, which is the procedure that logically follows and is defined as ‘an analytic statistical tool, which may enable us to find out what (if any) are the chief underlying dimensions of a set of variables, attributes, responses or observations’ (Oppenheim, 1992, p.166). In the case of the present study, a factor analysis was useful to verify whether the different items of the ATQ could be grouped into one or more variable or factors. In particular, I refer to the motivational, relational and cognitive variables and, of course, the affect variable.

### 5.2.1 Participants

The participants of this study consisted of five groups of multidisciplinary MHPs N=102, all attending part-time, in-service training in PSI workshops. The overall sample consisted of 37 men and 61 women (plus four participants who did not complete the gender question on the cover sheet). The mean age of the sample was 38.8 and the SD: 7.0. They reported the length of time spent in this or similar occupations as ranging from five months to 18 years, with a mean length of 9.5 years, SD: 6.9. The difference between the groups was the duration of the PSI training courses: one year for the first group, and six months for the others.



The occupational professions of the trainees are summarised in Table 5-10 below; four respondents did not report their profession.

**Table 5-10** Frequencies of the occupational professions of the PSI trainees

PROFESSION/OCCUPATION	FREQUENCY
Care Co-ordinator	12
Community Psychiatric Nurse	46
Occupational Therapist	10
Social Worker (not Approved)	7
Staff Grade Psychiatrist	5
PSI Co-ordinator	1
Assertive Outreach Worker	3
Approved Social Worker	7
Consultant	2
Day Manager	4
Counsellor	1

### **5.2.2 The psychometric properties of the ATQ**

In this section, the findings on the illustrate the validity and reliability of the ATQ, then I will consider the item analysis and the factor analysis.

#### **5.2.2.1 *Validity***

Oppenheim (1992) defined content validity as a means to establish whether the items of the scale are a well-balanced sample of the content domain to be measured. Content validity checks were conducted during the construction of the questionnaire. The content validity of the questionnaire was partly assured by systematically defining the items for each variable in the model from the literature (as in the tables above).

Face validity ‘describes the appearance of the questionnaire to respondents, whether or not it looks as if it is measuring what it claims to measure’ (Rust & Golombok, 1989).

Some experts in the field of training and transfer were consulted, a senior clinical psychologist, an expert senior researcher in the field of training and transfer in MHPs and two clinical psychologists, regarding the face validity of the questionnaire.

#### 5.2.2.2 *Reliability*

Two aspects of a scale's reliability are its internal consistency and its test-re-test reliability. It is recommended to check the reliability of a questionnaire in both respects (Kline, 1993).

Internal consistency is the degree to which the items that make up the scale are all measuring the same underlying attribute. The most common way to assess internal consistency is by using Cronbach's coefficient alpha. This statistic provides an indication of 'the average correlation among all of the items that make up the scale' (Pallant 2001, p.6).

Values range from 0 to 1, with higher values indicating greater reliability. Kline (1993) suggested the resulting figure should be 0.7 or above to advocate a reliable test.

Internal consistency checks were conducted for each separate variable within the five ATQ scales (motivational, cognitive, relational and affects, positive and negative), in order to verify that each item was placed within the correct variable and would therefore be reliable. The results are shown in Table 5-11 below.

Table 5-11 Reliability analysis for each item of the first three scales of the ATQ

Variable	Item Number	Alpha if item Deleted	Alpha
MOTIVATIONAL	1	0.4977	0.5147
	2	0.4720	
	3	0.4670	
	4	0.4593	
	5	0.4605	
	6	0.4716	
	7	0.8354	
	8	0.4770	
	9	0.4841	
	10	0.4712	
	11	0.4620	
COGNITION	12	0.5059	0.5285
	13	0.4778	
	14	0.5018	
	15	0.4974	
	16	0.5238	
	17	0.4641	
	18	0.5258	
	19	0.4917	
	20	0.5332	
	21	0.4946	
RELATIONAL	22	0.7531	0.7657
	23	0.7607	
	24	0.7357	
	25	0.7310	
	26	0.7438	
	27	0.7278	
	28	0.7545	
	29	0.7199	

The alpha reliability of the motivational scale was 0.51, indicating that the scale had poor reliability. However, after removing item 7, the alpha reliability of the scale increased to 0.83, which is quite acceptable. The cognitive scale had a poor internal consistency, with a Cronbach alpha coefficient of 0.52. It was not possible to improve the internal reliability by removing any of the items, so this result is to be considered unsatisfactory.

The relational scale showed an alpha reliability value of 0.76, thus indicating an adequate internal consistency.

The values of the reliability analysis are reported in the table below.

**Table 5-12 Reliability analysis of both the positive and negative emotion items in the ATQ during training and within the workplace**

Variable	Item	Alpha if Item Deleted (Training)	Alpha (Training)	Alpha if item Deleted (Workplace)	Alpha (Workplace)
Negative Emotion	Anger	0.7370	0.7526	0.7195	0.7722
	Anxiety	0.7244		0.7579	
	Boredom	0.7571		0.7634	
	Confusion	0.7097		0.7541	
	Shame	0.7367		0.7464	
	Envy	0.7322		0.7544	
	Fear	0.7316		0.7391	
	Guilt	0.7321		0.7526	
	Jealousy	0.7321		0.7905	
	Sadness	0.7267		0.7472	
Positive Emotion	Affection	0.7751	0.7582	0.7862	0.8136
	Excitement	0.7313		0.7815	
	Compassion	0.7023		0.7955	
	Happiness	0.6965		0.7810	
	Gratitude	0.7251		0.8031	
	Hopefulness	0.7238		0.7898	
	Pride	0.7163		0.8045	
	Relief	0.7760		0.7965	

Both scales received satisfactory alpha, showing good internal consistency.

5.2.2.3 Test-re-test

The second reliability assessment was a test- re-test reliability score for the whole of the ATQ. This is recommended by Anastasi and Urbina (1997) to highlight the stability of a test, and should be conducted to assess whether any change measured is due to the variables or the measurement’s unreliability. Six participants from the longer PSI training course were given the ATQ a second time a week apart. It is suggested that

ideally the correlation between scores at the two time points should be 0.8 or above, relating to 80% consistency, although 0.7 can be considered as the minimum reliability coefficient score (Kline, 1998) The results of the assessment are shown in Table 5-13 below, where both significant and non significant correlations are shown. Only two of the scales of the ATQ presented a significant correlation, thus suggesting that they are the only reliable scales. There were strong, significant correlations between the scores of the motivational scale ( $r=.923$ ,  $N=6$ ,  $p\ 0.01$ ) administered a week apart. The cognitive scale also presented strong significant correlations ( $r=.965$ ,  $N=6$ ,  $p\ 0.01$ ).

**Table 5-13 Correlation matrix of the ATQ scales, administered a week apart**

Variable	Correlations a week apart
Cognitive	.965(**)
Motivational	.923(**)
Relational	.650*
Neg.Emotions training	.783*
Pos.Emotions training	.742*
Neg. Emotions transfer	.472*
Pos. Emotions transfer	-.028*

\*\* Correlation is significant at the 0.01 level (2-tailed)

\* Correlation is not significant

**5.2.3 Item analysis and factor analysis**

As stated in the introduction to this chapter, the item and factor analyses are procedures that follow the reliability check. These are described in the sections below

**5.2.3.1 *Item analysis***

As recommended by Kline (1993), the first procedure implemented to check the construct validity of a scale, and then to check whether a questionnaire ‘measures what it is supposed to measure’ (Kline, 1993) is the item analysis. In this case, the variables of motivation, cognition, relational and affects (both during learning and during training).

Kline (1998) also recommended conducting an item analysis, as a precursor to the factor analysis, in order to highlight any discrepancies within the questionnaire beforehand. The rational item analysis is quite simple: 'If a test is measuring a variable, then it must be the case that each item is also measuring that variable' (Kline, 1998, p.71). This check will highlight whether, for example, each item under the construct of 'motivation', is actually measuring the motivational aspect of learning. Here, the method outlined in Anastasi and Urbina (1997) was followed.

The questionnaire responses were divided into five groups, following the structure of the questionnaire, that is, the five scales, to check whether each item was placed in the correct scale. The total scores were calculated and the mean for each item was correlated with this total score; items must correlate a score of 0.3 or higher to be significant and therefore be within the correct construct of the questionnaire (Kline 1998, p.71).

The results of the item analysis are shown below, where the Pearson's  $r$  correlation of each individual variable with the total score for the relational construct is shown. (Table 5-14 to Table 5-18).

The analysis suggests all the items within the questionnaire are placed under their correct construct, as all items correlate significantly with the total score, and thus the criterion, (Kline 1993), at the 0.01%. There was therefore no need to remove any items, either from the questionnaire or from further analysis; this implied preliminary support for the ATQ's construction.

Table 5-14 Item analysis for motivational variables

Item Number	Variable	Correlation with total score (motivational)
1	Attitudes	0.342**
2	Attitudes	0.509**
3	Mastery Orientation	0.559**
4	Mastery Orientation	0.609**
5	Performance Orientation	0.542**
6	Performance Orientation	0.479**
7	Goals: Achievement and Commitment	0.717**
8	Goals: Achievement and Commitment	0.482**
9	Self-Efficacy	0.392**
10	Self-Efficacy	0.485**
11	Motivational Aspect added.	0.600**

\*\* Correlation is significant at the 0.01 level (2-tailed).

Table 5-15 Item analysis for cognitive variables.

Item Number	Variable	Correlation with Total Score (knowledge)
12	Knowledge: Declarative & Procedural	0.436**
13	Knowledge: Declarative & Procedural	0.507**
14	Primary Appraisal	0.479**
15	Primary Appraisal	0.419**
16	Secondary Appraisal	0.324**
17	Secondary Appraisal	0.544**
18	Secondary Appraisal	0.451**
19	Metacognition: Awareness and Regulation	0.443**
20	Metacognition: Awareness and Regulation	0.339**
21	Metacognition: Awareness and Regulation	0.458**

\*\* Correlation is significant at the 0.01 level (2-tailed).

**Table 5-16 Item analysis for relational variables**

Item Number	Variable	Correlation with Total Score (relational)
22	Benefit	0.492**
23	Physical Environment	0.722**
24	Physical Environment	0.630**
25	Harm	0.632**
26	Warmth and Empathy	0.552**
27	Warmth and Empathy	0.638**
28	Support	0.528**
29	Support	0.648**

\*\* Correlation is significant at the 0.01 level (2-tailed).

Each emotion item was separated into emotion felt during training and emotion felt within the workplace, to correspond to the ATQ format. The resulting correlations are shown below (Table 5-17 and Table 5-18).

**Table 5-17 Item analysis for the positive emotion items in the ATQ**

Item Number	Emotion	Correlation with total score (Training)	Correlation with total score (Workplace)
30	Affection	0.305**	0.616**
35	Excitement	0.403**	0.604**
37	Compassion	0.371**	0.461**
39	Happiness	0.372**	0.472**
43	Gratitude	0.389**	0.558**
45	Hopefulness	0.403**	0.409**
46	Pride	0.438**	0.627**
47	Relief	0.436**	0.502**

\*\* Correlations significant at the 0.01 level (2-tailed).



Table 5-18 Item analysis for the negative emotion items in the ATQ

Item Number	Emotion	Correlation with total score (Training)	Correlation with total score (Workplace)
31	Anger	0.480**	0.656**
32	Anxiety	0.625**	0.584**
33	Boredom	0.285**	0.345**
34	Confusion	0.472**	0.562**
36	Shame	0.435**	0.460**
38	Envy	0.470**	0.554**
40	Fear	0.533**	0.626**
42	Guilt	0.479**	0.607**
44	Jealousy	0.355**	0.331**
47	Sadness	0.564**	0.657**

\*\* Correlations significant at the 0.01 level (2-tailed).

Both tables highlight a strong significant correlation between all items within the positive and negative construct of emotion, each showing significant correlations with the total score being beyond 0.3 (Kline 1993). For example, excitement ( $r= 0.403$  &  $0.604$ ,  $p= 0.01$ , Table 5-17) and confusion ( $r=0.472$  &  $0.562$ ,  $p= 0.01$ , Table 5-18). This indicates that the items of each scale are all measuring the relevant variable, for example all the items in Table 5-16 are measuring the variable ‘relation’.

5.2.4 **Factor analysis**

The final validity check for any questionnaire (Kline 1993) and therefore for the five sections of the ATQ, was a factor analysis. Factor analysis is a procedure often used in the ‘development and evaluation of tests and scales’ (Pallant, 2001, p.151), in order to reduce the number of variables to underlying factors. In psychometrics, factor analysis is particularly relevant to construct validity. Dancey and Reidy (2002) explained that ‘when researchers design questionnaires, they usually have several questions relating to one construct of an idea, that is certain questions correlate with each other because they are measuring the same construct. Factor analysis can identify such patterns of correlations’

(p.401). Factor analysis allows the interpretation of a complex set of variables reducing them to a smaller number of factors. In order to validate the variables of the five sections (cognition, motivation, relation, affects in training, affects in transfer), the analysis should identified principal ‘components’ within the data and allowed investigation of whether the scales actually contain the variables mentioned (Anastasi & Urbina 1997, p.89).

Only the items from the scales that reported good reliability values were considered for the factor analysis. Thus, the ten items of the motivational scale (item number 7 was excluded after the internal consistency checks), the 8 of the relational scale, the 10 of the affects in training scale and the 18 of the affects in transfer scale were separately subjected to a principal component analysis using SPSS. Each time, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients of .3 and above. The factorability of the correlation matrix was also supported by the Kaiser-Meyer-Olkin value and the Barlett’s test of sphericity.

#### ***5.2.4.1 Factor extraction***

Dancey and Reidy (2002) suggested that, ‘we want to account for as much variance as possible, while keeping the number of factors extracted as small as possible’ (p.422). According to the them, there are three main criteria to consider when deciding how many factors are to be kept:

- Look at the eigenvalue. Factors to keep are those who have an eigenvalue of 1.00.

The eigenvalue shows the proportion of variance accounted for each factor.

- Look at how much variance the factors account for. In theory, one should try to account for 75% of the variance. However, it is also important to keep the least number of factors in order to explain the most variance.
- Look at the screeplot produced by the SPSS, where the number of factors is plotted against variance accounted for. 'The idea is that factors drop off to some level and then they plateau' (p. 423). The factors before the point where the plateau levels out (also called the 'elbow') have to be retained.

Dancey and Reidy (2002) concluded that 'all criteria must be used together to decide how many factors to keep. A good researcher needs to take everything into consideration in coming to a decision on how many factors to retain' (p.424).

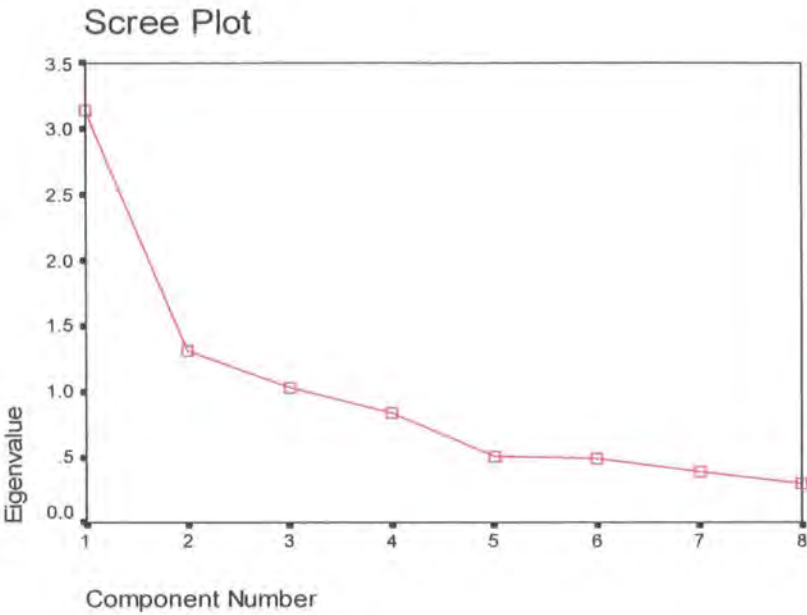
I will now present the factor extraction procedures for each of the different parts of the ATQ, and I will follow the above criteria to decide each time how many factors to extract.

#### **5.2.4.2 Relational scale**

The principal component analysis revealed the presence of three components with eigenvalues exceeding 1. The second criterion for deciding how many factors to retain is by looking at the screeplot. Finally, the first component explained 39% of the variation, the second 16% and the third 12%. An inspection of the screeplot (Figure 5-1) revealed a first break after the second component, thus indicating the presence of a first component with the 'elbow' of the plot suggesting that a second may be included (Pallant, 2001). It

was decided to retain the first two components that together accounted for 55% of the variation, for further investigation.

Figure 5-1 Screeplot showing the number of factors for the relational scale



To aid with the interpretation of these two components, a rotation was performed. Dancey and Reidy (2002) suggested that the most common method to rotate axes is the varimax rotation. As a result of varimax rotation, high correlations will be maximized, while the low correlations will be minimized. They also stated that, ‘rotation is a well-established technique that makes interpretation easier, because the differences in the loadings of the variable of each factor are emphasized’ (p.421). The rotated solution, presented in Table 5-19 revealed that one component was showing a larger number of strong loadings and a second component showing 3 loadings, explaining respectively 39% and 16% of the variance. The results of this analysis are consistent with the idea that the variables (items) of the relational scale mainly load on one component, and then they are all measuring the same construct (the relational aspect).

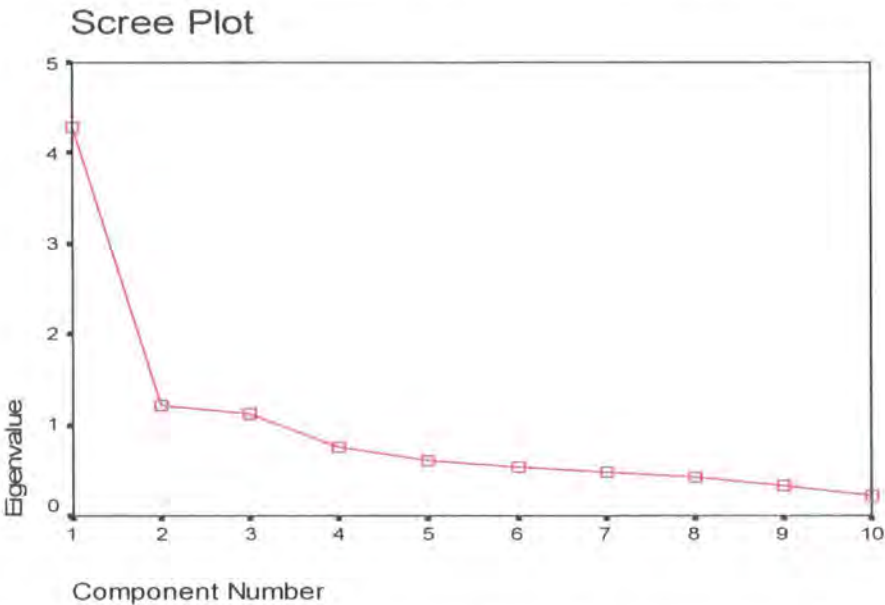
Table 5-19 Rotated component matrix, relational scale

ITEMS	Component	
	1	2
25.Harm	.849	
26.Warmth and Empathy	.766	
27.Warmth and Empathy	.761	
23. Physical environment	.475	
22.Benefit	.434	.304
24. Physical environment		.814
28.Support		.799
29.Support	.361	.718

5.2.4.3 Motivational scale

A principal component analysis revealed the presence of three components with eigenvalues exceeding 1, with the first component explaining 43% of the variation, the second 12% and the third 11%. An inspection of the screeplot (Figure 5-2) revealed a first break after the second component, thus indicating the presence of a first component.

Figure 5-2 Screeplot showing the number of factors for the motivational scale



It was decided to retain two components for further investigation. As for the relational scale, a varimax rotation was performed. The rotated solution, presented in Table 5-20, revealed that one component was showing a larger number of strong loadings (8) and a

second component was showing 2 loadings, explaining 42% and 12% of the variance respectively. The results of this analysis are consistent with the idea that the variables of the motivational scale mainly load on one component.

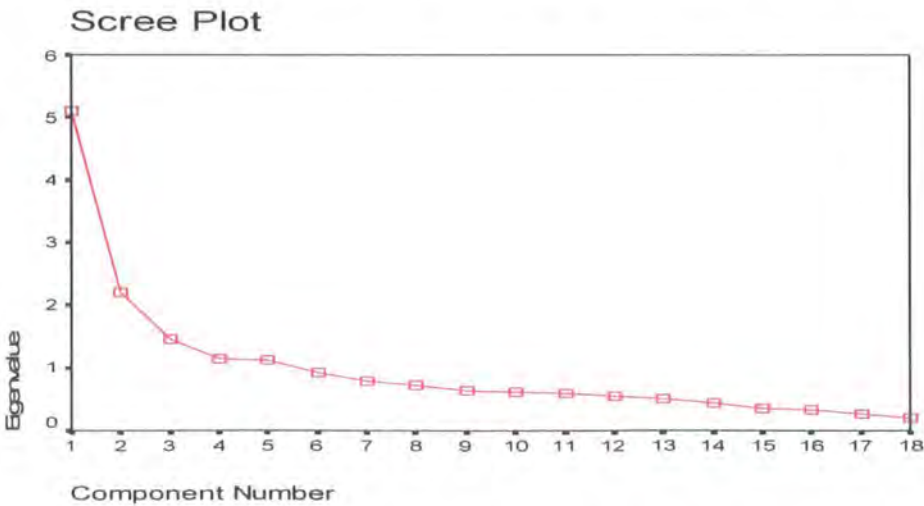
Table 5-20 Rotated component matrix, motivational scale

ITEMs	Component	
	1	2
8.Goals:achievement and commitment	.774	
2.Attitudes	.736	
1.Attitudes	.691	
9.Self-efficacy	.648	
4.Motivational disposition: mastery orientation	.614	.468
11.Motivational aspect added by FW	.583	.439
10.Self-efficacy	.532	.332
3.Disposition:mastery orientation	.487	.460
6.Motivational Disposition: performance orientation		.847
5. Motivational Disposition: performance orientation		.807

5.2.4.4 Affect in training

A principal component analysis revealed the presence of five components with eigenvalues exceeding 1, with the first two explaining respectively 28% and 12% of the variation. An inspection of the screeplot (Figure 5-3) revealed a first break after the second component, thus clearly indicating the presence of two components.

Figure 5-3 Screeplot showing the number of factors for the affect in training scale



It was decided to retain these two components and perform a varimax rotation. The rotated solution, presented in Table 5-21, revealed the presence of a simple structure, with both components showing a number of strong loadings, explaining 22% of the variance for the first component and 18% of the variance for the second. The interpretation of the two components is consistent with the existence of positive and negative affects in training, with negative affects loading on component 1 and positive affects loading on component 2.

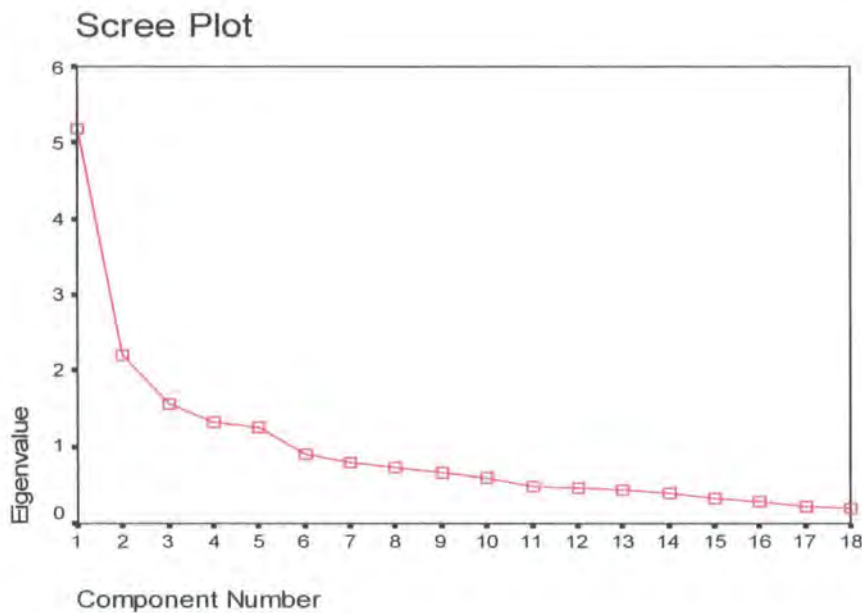
Table 5-21 Rotated component matrix, affect in training scale

	Component	
	1	2
Shame	.755	
Envy	.692	
Fear	.667	
Jealousy	.653	
Guilt	.629	
Confusion	.624	
Anger	.592	
Anxiety	.569	.374
Boredom	.499	
Sadness	.397	.331
Compassion	.360	.357
Happiness		.742
Gratitude		.735
Excitement		.700
Hopefulness		.684
Pride		.515
Affection		.459
Relief	.316	.407

5.2.4.5 *Affect in transfer*

A principal component analysis revealed the presence of five components with eigenvalues exceeding 1, with the first two explaining respectively 29% and 12% of the variation. An inspection of the screeplot revealed a first break after the second component, thus clearly indicating the presence of two components.

Figure 5-4 Screeplot showing the number of factors for the affect in transfer scale



It was decided to retain these two components and perform a varimax. The rotated solution, presented in Table 5-22, revealed the presence of a simple structure, with both components showing a number of strong loadings, explaining 29% of the variance for the first component and 12% of the variance for the second. The interpretation of the two components is consistent with the existence of positive and negative affects in transfer, with positive affects loading on component 1 and negative affects loading on component 2.



Table 5-22 Rotated component matrix, affect in transfer scale

	Component	
	1	2
Happiness	.764	
Hopefulness	.743	
Excitement	.703	
Compassion	.649	
Relief	.613	
Affection	.605	.335
Gratitude	.546	
Pride	.511	.311
Anger		.711
Fear		.647
Guilt		.626
Envy		.605
Shame		.575
Anxiety		.511
Boredom		.507
Sadness	.475	.503
Confusion		.503
Jealousy		.440

In conclusion, these results suggested that all but one of the scales of the ATQ presented good internal consistency. The scale that presented low internal reliability data was the cognitive scale. However, the only two scales that reported test-retest reliability were the motivational and cognitive scale.

Once the psychometric properties of the questionnaire have been investigated, in the next section of the Chapter I will explore possible connections between training, transfer and emotions.

5.2.5    **The operationalisation of Lazarus model**

The table below (Table 5-23) shows the results for the motivational and relational scale of the ATQ. The data indicated that the respondents agreed with most of the items in the motivational section of the questionnaire. This suggests that, for example, they had positive attitudes towards PSI, that they were keen to increase their PSI competences, that they were committed to achieve training targets and that they felt self-confident. The relational aspects of training obtained some neutral scores, for example the ‘physical environment’ items. This data is in contrast with those obtained from the interviews, where most of the trainees complained about the classroom where training was taking place. This might suggest that the physical environment was problematic only for that small group of trainees. Overall, trainees agreed that support (both from fellow trainees and at work) was important for their training, as well as an empathic and warm relationship with the trainer. Unfortunately, data from the cognitive scale could not be reported, due to the unreliability of the scale.

Table 5-23 Means and standard deviations for the motivational scales.  
(Scale: 1=strongly disagree 5=strongly agree)

ASPECTS OF LEARNING	VARIABLE/ITEM	MEAN	Std. Dev.
Motivational	Attitudes	4.1	0.4
	Mastery orientation	4.3	0.5
	Performance orientation	3.8	0.7
	Goals	3.9	0.5
	Self-efficacy	3.9	0.6
Relational	Benefit	3.9	0.9
	Harm	3.5	0.9
	Physical environment	3.1	0.7
	Warmth and Empathy	3.8	0.7
	Support	3.6	0.8

Emotions in training were experienced only ‘sometimes’ and ‘not very often’ in contrast to what was reported in the interviews. Data are shown in Table 5-24

**Table 5-24 Means and standard deviations for the affect in training**  
(Scale: 1=never 5=always)

Affect in Training	Mean	SD
Affection	2.9	.8
Anger	2.2	.9
Anxiety	3.	.9
Boredom	2.6	.7
Confusion	2.9	.7
Excitement	2.6	.9
Shame	1.6	.8
Compassion	3.1	.8
Envy	1.8	1
Happiness	3.3	.7
Fear	2.1	1
Gratitude	2.9	.9
Guilt	1.8	.8
Hopefulness	3.6	.8
Jealousy	1.5	.7
Pride	2.7	.9
Relief	3	.9
Sadness	2	.9

Similar results were obtained for the ‘emotions’ experience during transfer of PSI skills when working with clients. However, in both cases, standard deviations reported some high values, thus suggesting a certain amount of variability amongst respondents. It might be the case that trainees feel different emotions, and react in a number of different ways.

Table 5-25 Means and standard deviations for the affect in transfer scale  
(Scale: 1=never 5=always)

Affect in Transfer	Mean	SD
Affection	2.9	1
Anger	2.6	1
Anxiety	3.3	.8
Boredom	1.7	.79
Confusion	3.	.8
Excitement	2.9	1
Shame	1.5	.8
Compassion	3.7	.7
Envy	1.5	.9
Happiness	3.2	.8
Fear	2.5	1
Gratitude	2.6	1
Guilt	2	1
Hopefulness	3.5	.8
Jealousy	1.5	1
Pride	2.9	.9
Relief	3.	.86
Sadness	2.5	1.

5.2.6 Emotion and transfer of training

The inter-correlation between emotions experienced in training and emotions experienced in the workplace was investigated using bivariate correlations. These were performed between positive and negative emotions felt during training, and those experienced within the workplace, to verify if there was any relationship between the two. The resulting bivariate correlation matrix can be seen in Table 5-26.

Table 5-26 Pearson’s-R correlations between emotions felt, in training and the workplace

	Negative Emotions in Training	Negative Emotions in the Workplace	Positive Emotions in Training	Positive Emotions in the Workplace
Negative Emotions in Training	-	0.581**	0.614**	0.535**
Negative Emotions in the Workplace	0.581**	-	0.666**	0.432**
Positive Emotions in Training	0.614**	0.666**	-	0.225*
Positive Emotions in the Workplace	0.535**	0.432**	0.225*	-

\*\* Correlation is significant at the 0.01 level (2-tailed)

\* Correlation is significant at the 0.05 level (2-tailed)

Table 5-26 indicates how emotions felt during training have a significant relationship with those felt when in the workplace. For example, experiencing negative emotions during training correlates highly with experiencing negative emotions within the workplace ( $r= 0.581$   $p= 0.01$ , Table 15). However, it also correlates with experiencing positive emotions in the workplace ( $r = 0.535$ ,  $p= 0.01$ ). All of the variables correlate significantly with one another, suggesting that experiencing any emotion during training is likely to influence experiencing emotion within the workplace. This verified that emotions are present in both the learning and transfer situations and suggested that further analyses were warranted to validate whether positive and negative emotions exerted a significant influence on the transfer of newly learnt skills when working with clients.

5.2.7 Generalistion of training and the ATQ

The data collected in the preliminary investigation already described (section 5.1.8) indicated some correlations between the emotions expressed by some of the interviewees and the transfer rates measured with the GQ. The correlational analysis between the ATQ and the GQ will now allow me to explore the relationship between the three variables of the Lazarus model (cognitive, motivational and relational) and transfer rates measured by the GQ.

Many respondents found it difficult to fill in the whole GQ, probably because it took a long time to complete. Consequently, a shorter version of the GQ had to be created, and only 55 of these questionnaires could be administered. Unfortunately, only 46 participants managed to correctly fill in the ‘before’ and ‘after’ generalisation figures, reducing the sample size substantially. Furthermore, this reduced the reliability of the data.

In order to measure the extent to which training in particular skills had been transferred to the workplace, a T-test was carried out, assessing whether or not the differences in the mean scores between the start and end of the course were statistically significant. There was a statistically significant increase in the use of self-rated PSI skills (Table 5-27).

**Table 5-27 Means and standard deviations of the use of PSI techniques before and after training**

Before training		After training	
Mean	SD	Mean	SD
2.35	.62*	3.3	.08

\*Paired t-test  $p < .0005$ .

A generalisation variable was computed by subtracting the mean score of the use of self-rated PSI methods prior to the training from the mean score of the use subsequent to training, generating a single variable to be used as the transfer, or generalisation, figure. Then a correlation analysis was completed, correlating each of the items in the ATQ (numbers 1-47a &b) with the generalisation figure, in order to highlight any significant correlations between them. Only the 46 participants who had completed the short version of the GQ were considered.

**Table 5-28**Significant Pearson’s-R correlation between items of the ATQ and the generalisation variable.

Item Number	Item Name	Variable	Correlation with Generalization score
13	Knowledge	Cognition	0.337*
18	Appraisal		-0.300*
25	Harm	Relational	0.338*
29	Support		0.323*

\* Significant at the 0.05 level (2-Tailed).

Two of the relational items, ‘harm’ and ‘support’ correlated significantly and positively with generalisation, (Table 5-28) together with the cognitive variable ‘knowledge’ (Table 5-28). The further cognitive variable ‘appraisal’ correlated significantly yet negatively with generalisation ( $r = -0.300$ ,  $p = 0.05$ , Table 16).

In conclusion, only four of the items correlated significantly with the generalisation variable. It is possible that the study was statistically underpowered and that some of the other correlations would have proved to be statistically significant if the sample size had not been reduced. There were some significant correlations between positive and negative emotions (both in training and transfer). However, the direction of these correlations could not be estimated.

### 5.3 Study 3

In this section I will present the outcomes of introducing the intervention, RCS, based on Lazarus's model (1991) as described in Chapter 3 (in section 3.3, p 69).

The findings are reported in two sections. In the first part of the study, following with a N=1 approach, I will present a number of graphs showing the possible links between the independent variable (the administration of the extra RCS) and the other dependent variables (the coping strategies). The stress, variable sense of mastery and strain, and transfer will also be included in the figures, to check any possible associations with the coping variables. In the second part, I will support the visual inspection technique by auto-regression analyses.

#### 5.3.1 Sample

The sample consisted of four mental health clinicians: one man and three women, including two care managers, one a social worker, the other a CPN, one staff nurse and one support worker. Their average age was 38 years (SD 6.16) and they had been in their present positions for an average of one year and ten months (SD16.62, range from four years to three months). One participant held a BSc Sociology degree and a Diploma in Social Work, two were qualified Registered Mental Health Nurses and one had no formal qualification (the support worker).



5.3.2 Extra revitalised supervision and coping strategies.

As evident from the charts below, the RCS was implemented with the supervisees at different points in time. This time-lagged method follows the multiple baseline design approach described above.

According to multiple baseline designs, one should start the intervention (the independent variable) once each participant’s baseline shows a stable pattern. However, in the present study there was no stable baseline for any of the participants, and it was decided to start the intervention after three or four days in which the values of the dependent variables were not extreme. The RCS was then applied sequentially and cumulatively to the four supervisees.

Table 5-29 summarises the duration of the baseline, intervention and post intervention period for each of the participants.

**Table 5-29 Number of days of the baseline, intervention and post intervention period for each participant**

Participant	Baseline	Intervention	Post intervention
1	18	11	5
2	28	12	3
3	30	17	6
4	38	20	5

### 5.3.3 Multiple baselines across individuals

In order to highlight any possible associations amongst the variables examined, four variables are plotted in each chart: a different coping strategy (in pink), and then the scores of the other three variables. Two of these measure emotions (mastery, strain and stress). The forth measures transfer of training. These are the same in each chart. For each chart, the definition of the given coping strategy, as described in the Daily Diary, is reported. I will comment first on emotions and on transfer of training and then on each coping strategy in turn. Regarding the stress, sense of mastery and transfer variables, the peaks and troughs in the lines showed considerable daily variability for each participant. It was difficult to detect any effects because changes were often inconsistent.

#### 5.3.3.1 *Stress*

Considering the stress variable (blue line), Participant 1 showed a slight decrease during the intervention phase, compared to the baseline and post intervention measures. However, the stress data for Participant 2 seemed to be unchanged during the three phases of the experiment. The stress scores for Participant 3 seemed to increase towards the end of the intervention phase. Participant 4 showed great daily variability in the stress level. One of the expected effects of the RCS was to improve coping strategies, thus producing a reduction in stress. However, this is not evident in any of the charts. No patterns were found between stress and transfer for any of the participants.

#### 5.3.3.2 *Mastery and strain*

Participant 1 showed no changes in the levels of mastery and strain. However, Participant 2 showed an increased sense of mastery towards the end of the intervention phase, which

also corresponded to a higher level of transfer. However, no similar pattern was found for the other two participants (although Participant 2 showed some association at the beginning of the intervention phase). Participant 4 presented a certain amount of variability.

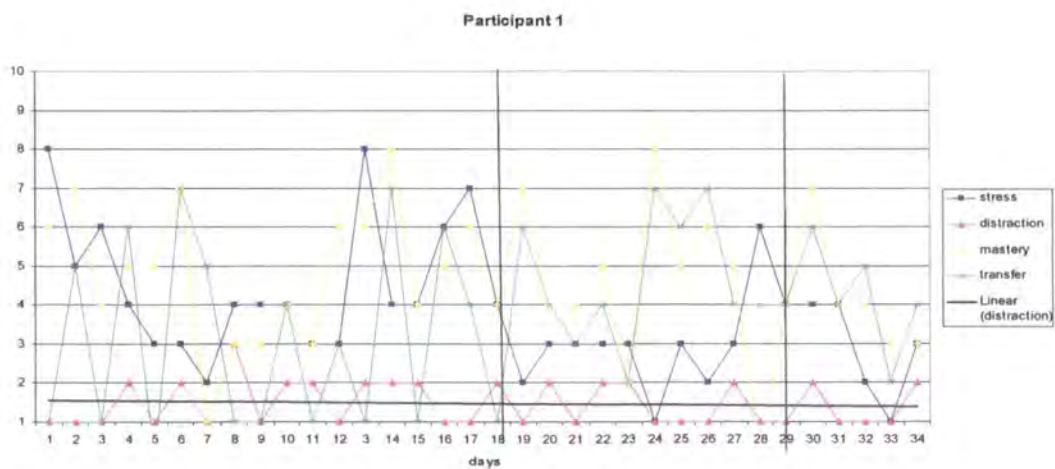
5.3.3.3 *Transfer*

The transfer variable seemed to decrease when distraction increased, especially at the beginning of the intervention although was less evident towards the end of the intervention phase. In Participant 1, action was associated with good transfer and good sense of mastery. A clear improvement in the use of PSI techniques was not evident with any of the four participants.

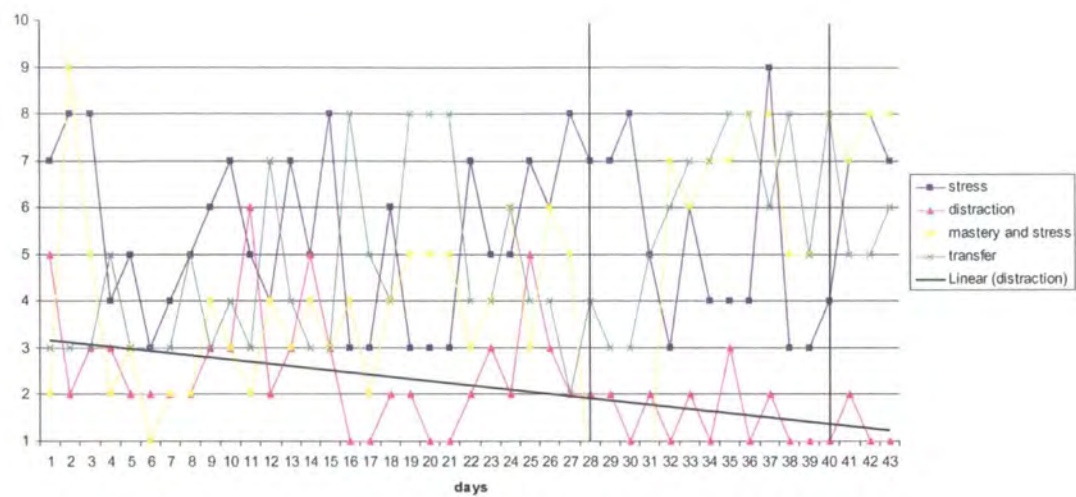
5.3.3.4 *Distraction*

‘Diverted attention away from the problem by thinking about other things or engaging in some activity’ (Stone & Neal, 1984)

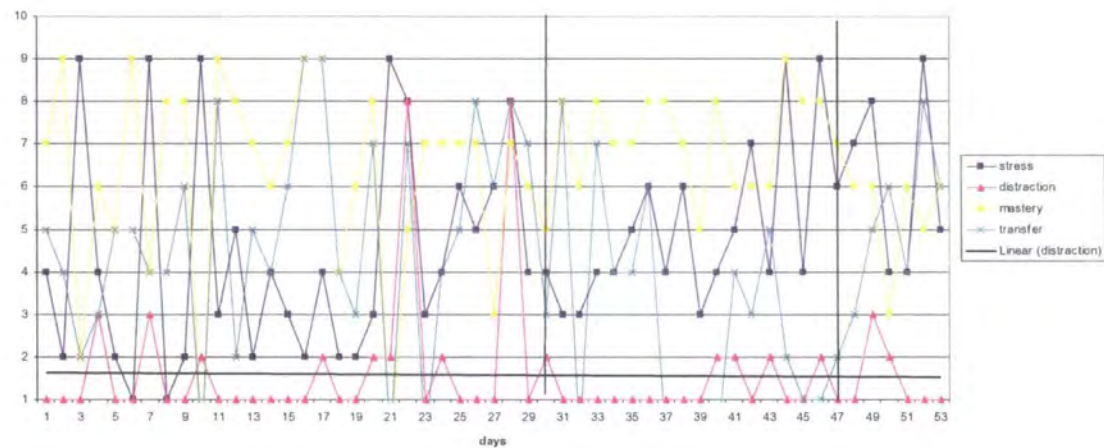
Figure 5-5 Distraction, stress, mastery and transfer during baseline, intervention and post intervention

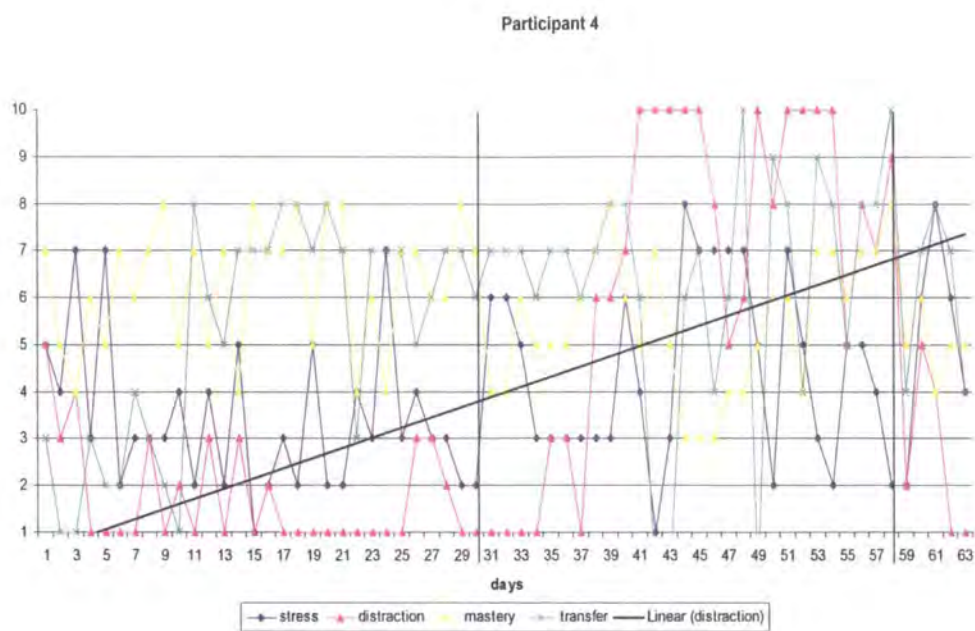


participant 2



Participant 3



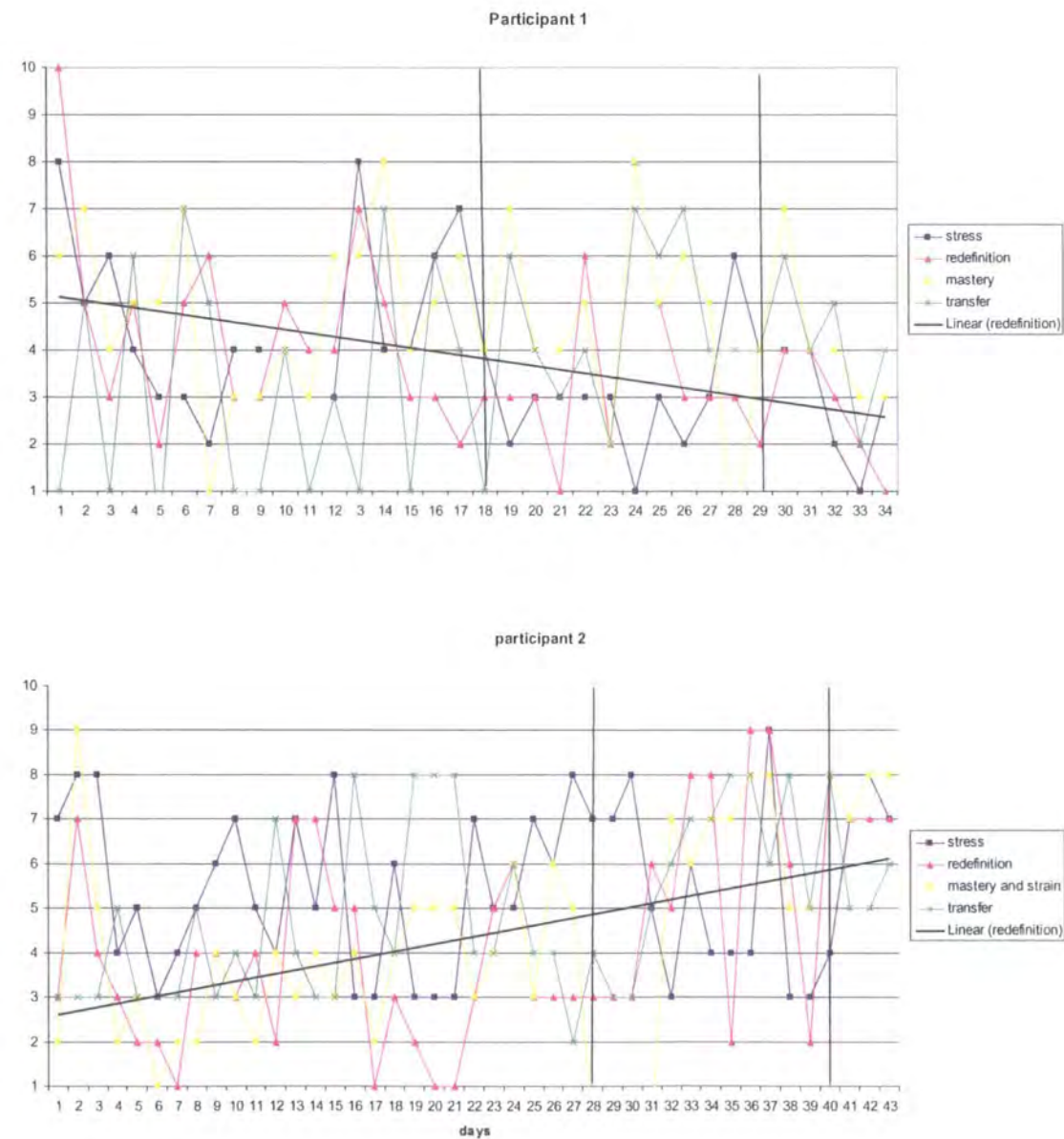


The intervention did not lead to apparent effects in Participant 1 in this domain (there are no differences in the use of distraction before, during and after the intervention), whereas a slight decrease existed in Participant 2 (there is only one peak, compared to the baseline period). Participant 3 showed a slight reduction in the use of this coping strategy, while Participant 4 showed an increase in the use of distraction towards the end of the intervention phase. The five days following the intervention demonstrated a decrease in the use of distraction. Overall, no clear pattern emerged, with the intervention showing a slight effect (decrease in the use of ‘distraction’) on Participants 2 and 3, and an increase on Participant 4.

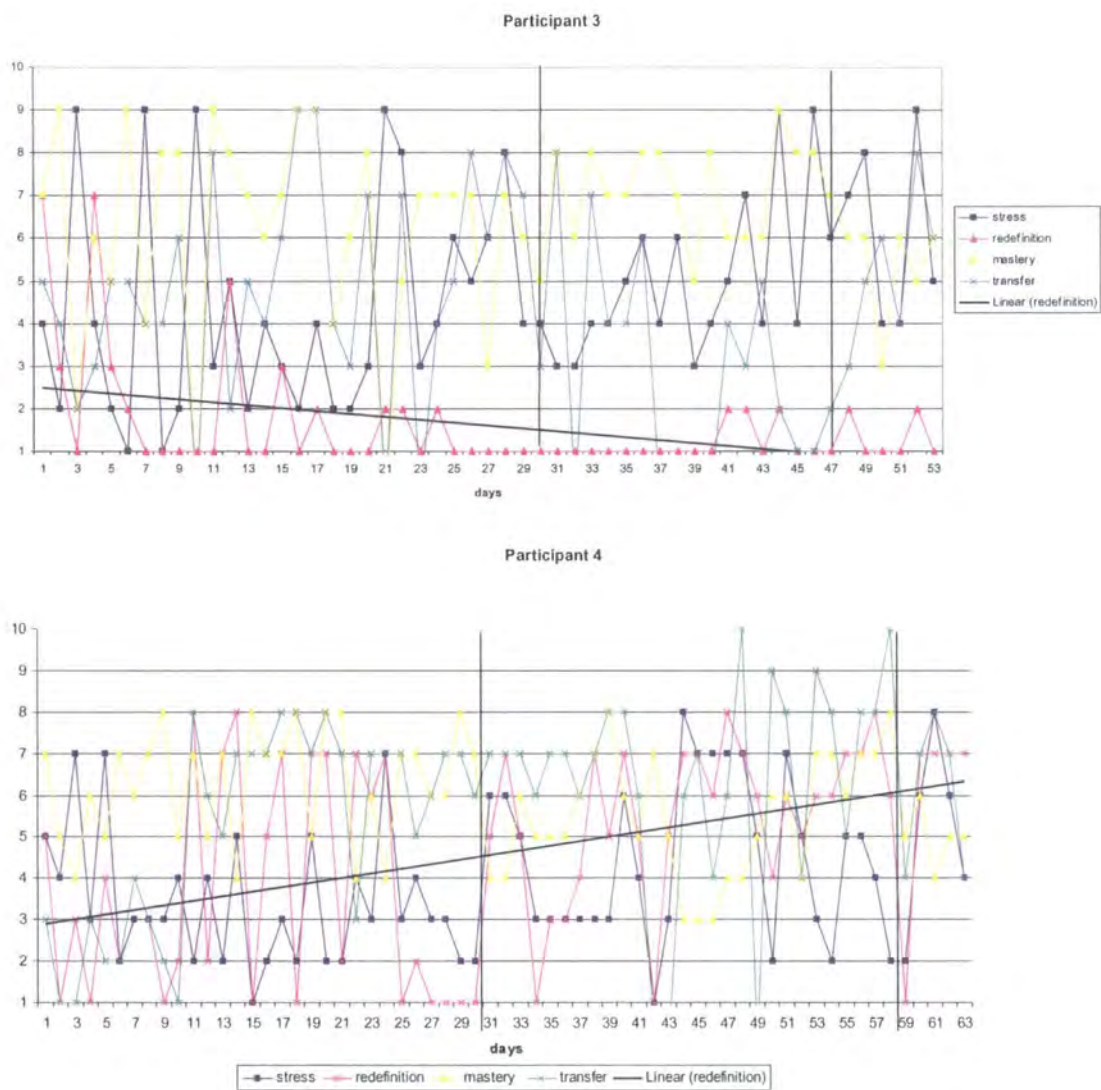
5.3.3.5 *Redefinition*

‘Tried to see the problem in a different light that made it seem more bearable’ (Stone & Neal, 1984)

Figure 5-6 Redefinition, stress, mastery and transfer during baseline, intervention and post intervention





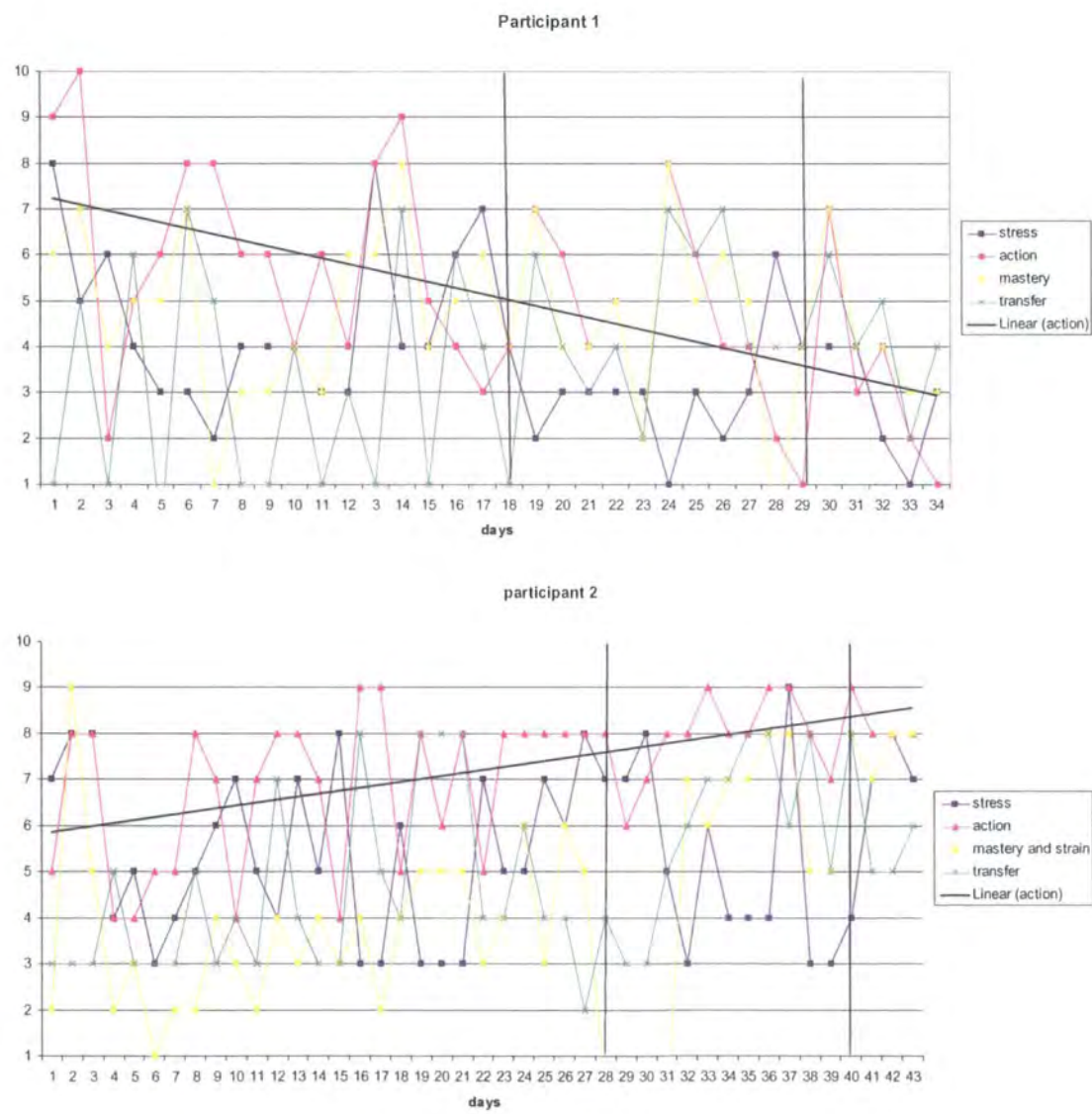


Even in this case, no clear and stable change emerged. The trend line highlighted a minimum amount of decrease in the use of ‘redefinition’ for Participant 1. Some improvement emerged for the other three participants of the study, although the visual inspection highlighted little stability.

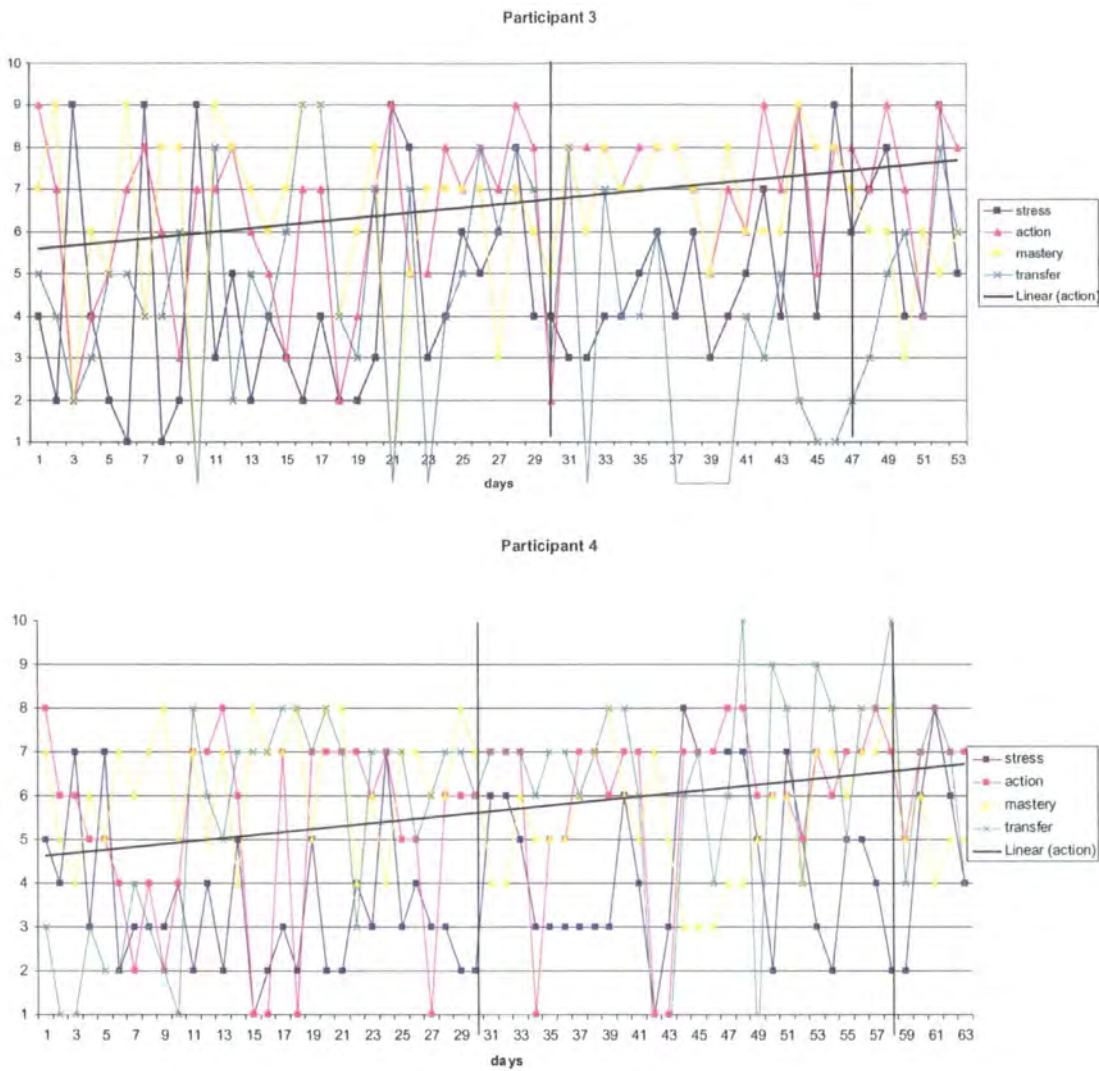
5.3.3.6 Action

‘Thought about solutions to the problem, gathered information about it, or actually did something to try to solve it’ (Stone & Neal, 1984)

Figure 5-7 Action, stress, mastery and transfer during baseline, intervention and post intervention periods





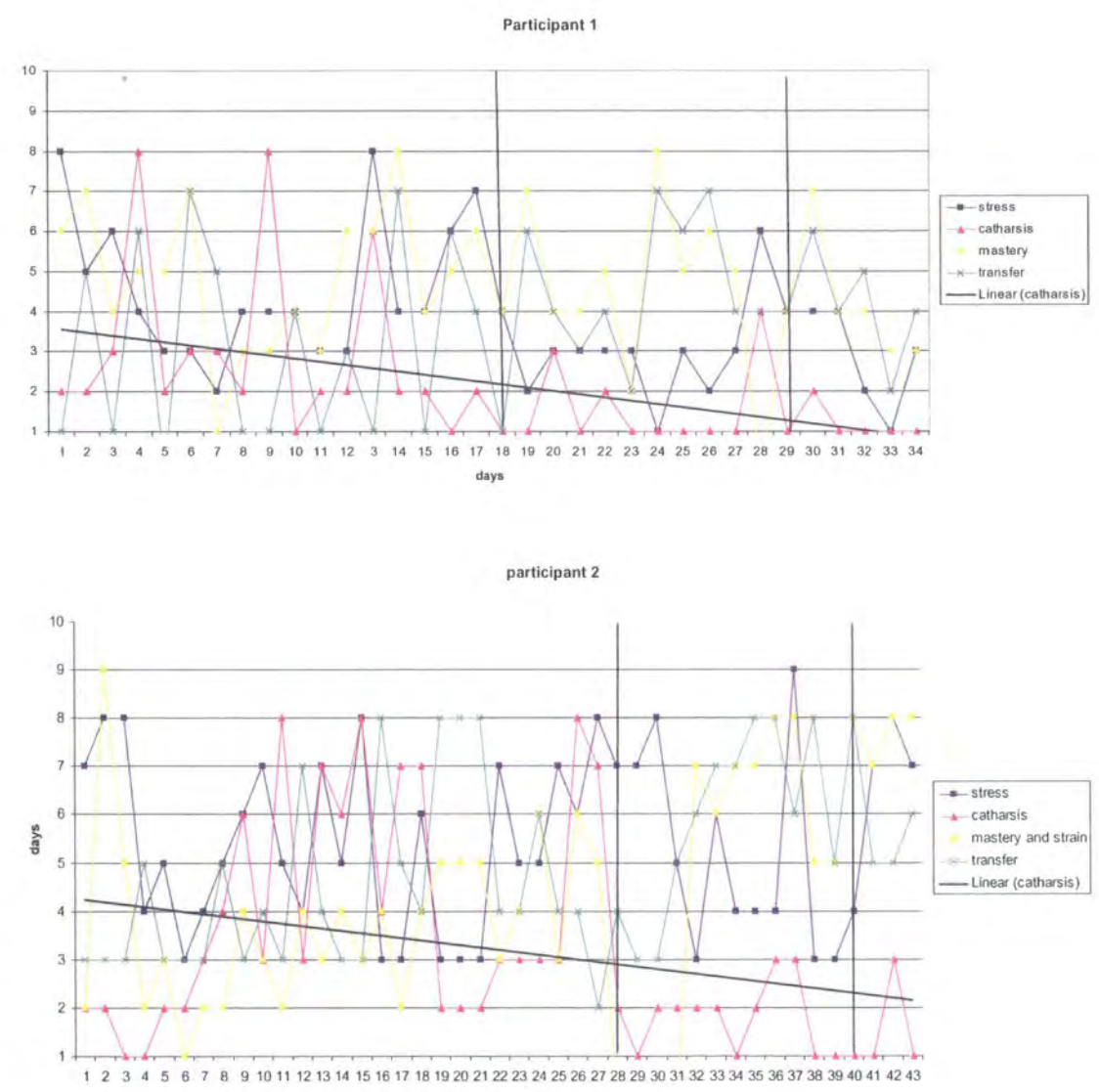


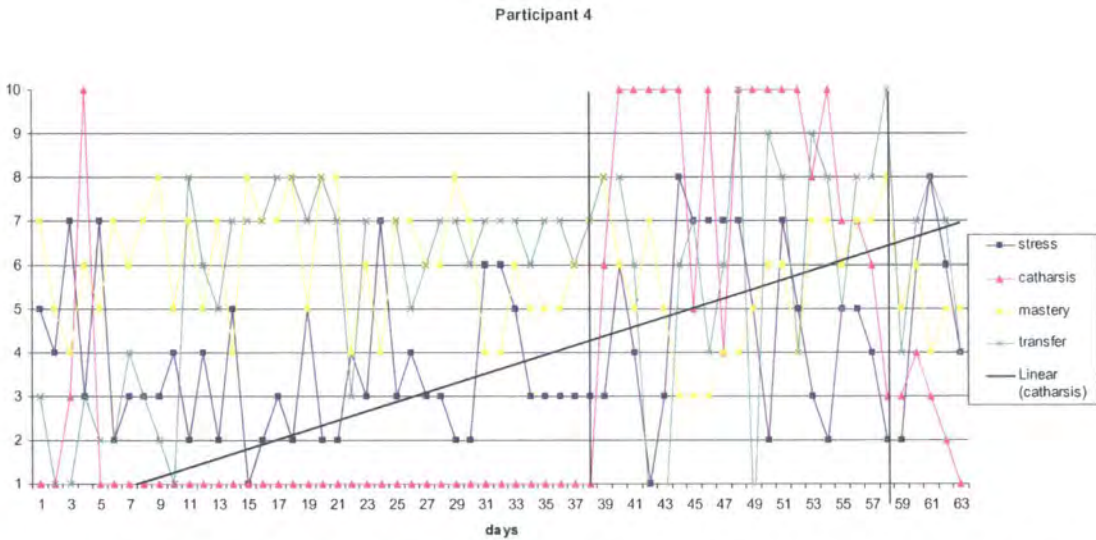
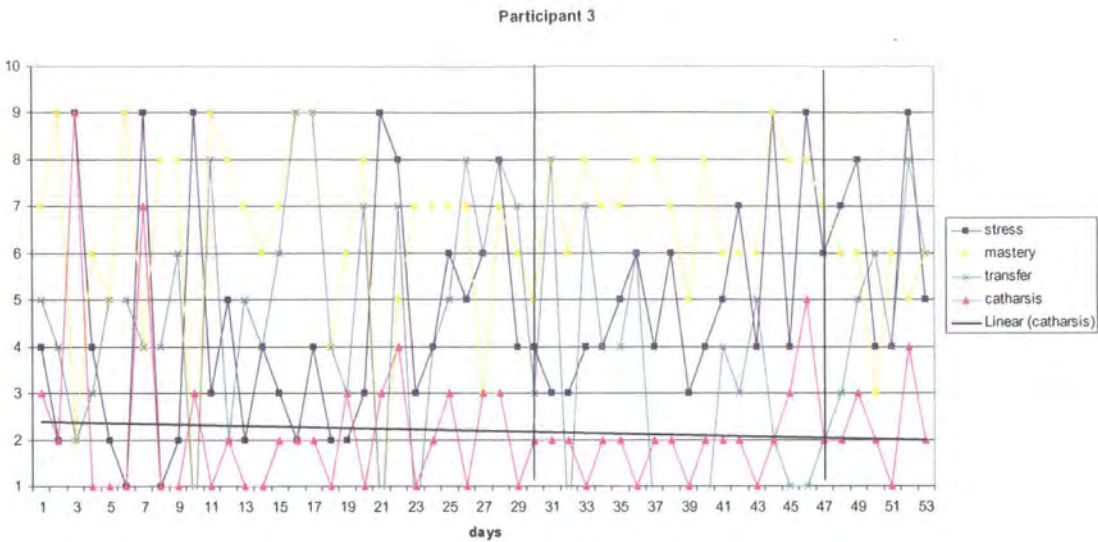
The visual inspection of ‘action’ suggested a decrease in the use of this coping strategy in Participant 1 during both the intervention and the post intervention phase. In contrast, there was an increase in the use of ‘action’ for Participants 2 and 3. Participant 4 showed signs of improvement, however with great daily variability.

5.3.3.7 Catharsis

‘Expressed emotions in response to the problem to reduce tension, anxiety or frustration’  
(Stone & Neal, 1984)

Figure 5-8 Catharsis, stress, mastery and transfer during baseline, intervention and post intervention



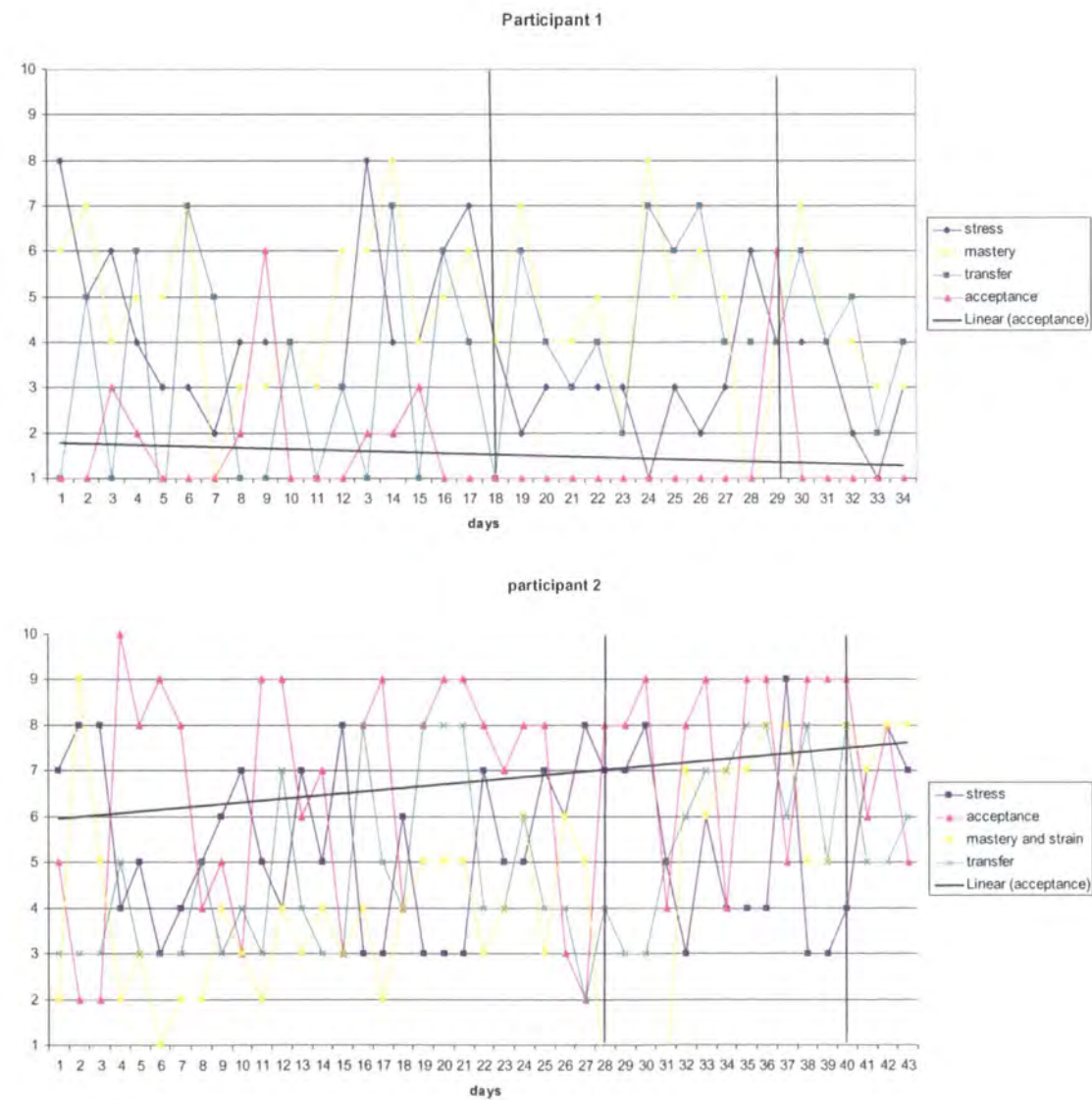


Regarding this coping strategy, the trend line showed some decrease in its use in the first three participants and an evident increase, with low daily variability, for Participant 4. However, for Participants 1 and 3 the change in behaviour took place before the introduction of the intervention, so it cannot be assumed that the changes in the use of catharsis were due to the RCS.

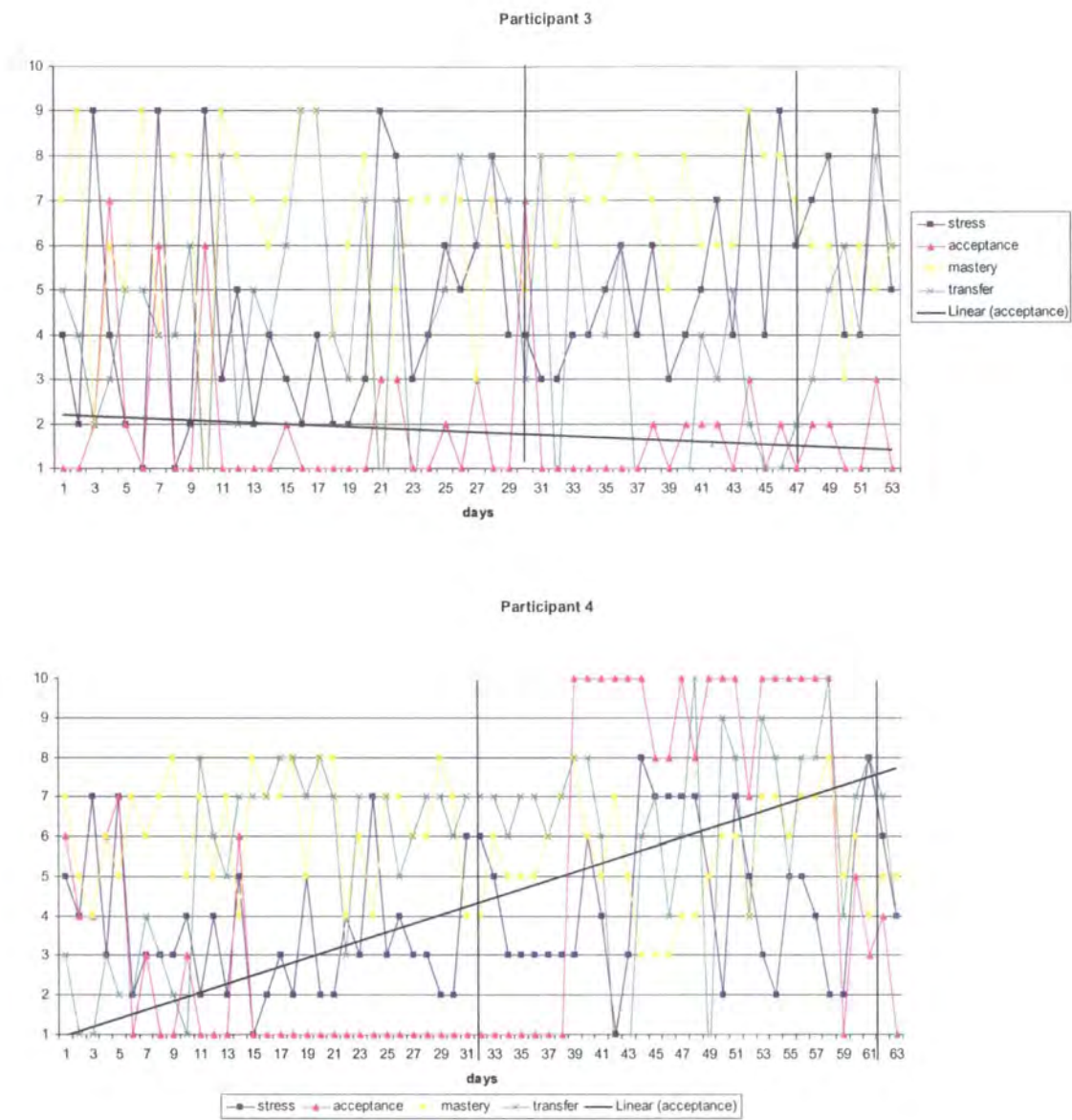
5.3.3.8 Acceptance

‘Accepted that the problem had occurred, but that nothing could be done about it’ (Stone & Neal, 1984)

Figure 5-9 Acceptance, stress, mastery and transfer during baseline, intervention and post intervention







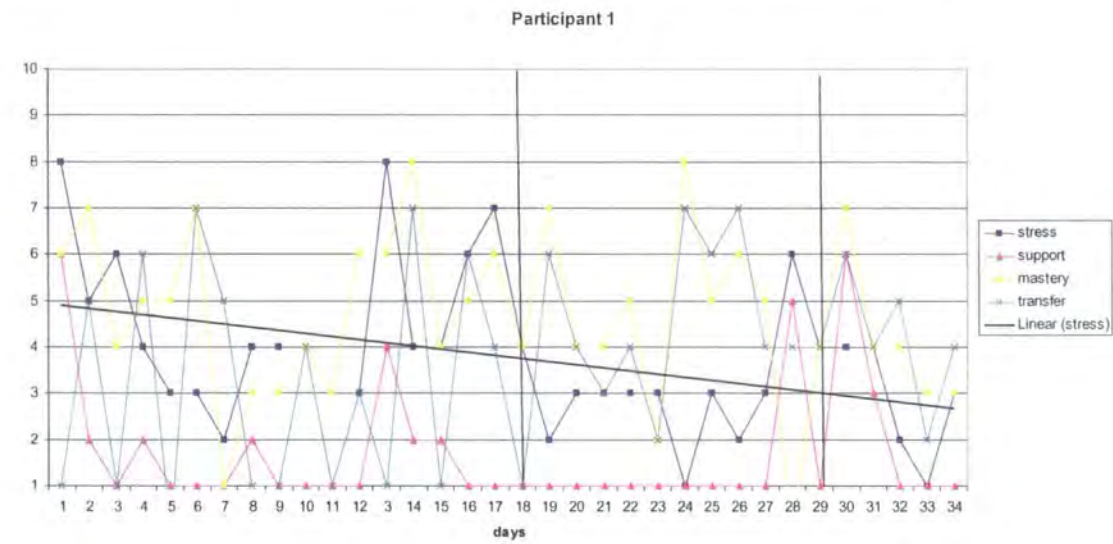
The trend line suggested a decrease in the use of ‘acceptance’ for Participant 1, although changes in the scores happened before the intervention. However, during the intervention phase, scores were consistently low. Participant 2 showed an increase in the use of ‘acceptance’. However, the large amount of daily variability does not provide a clear picture. Participant 3 reported a decrease in the scores of this coping strategy and a reduced daily variation compared to the pre-intervention phase. Finally, Participant 4

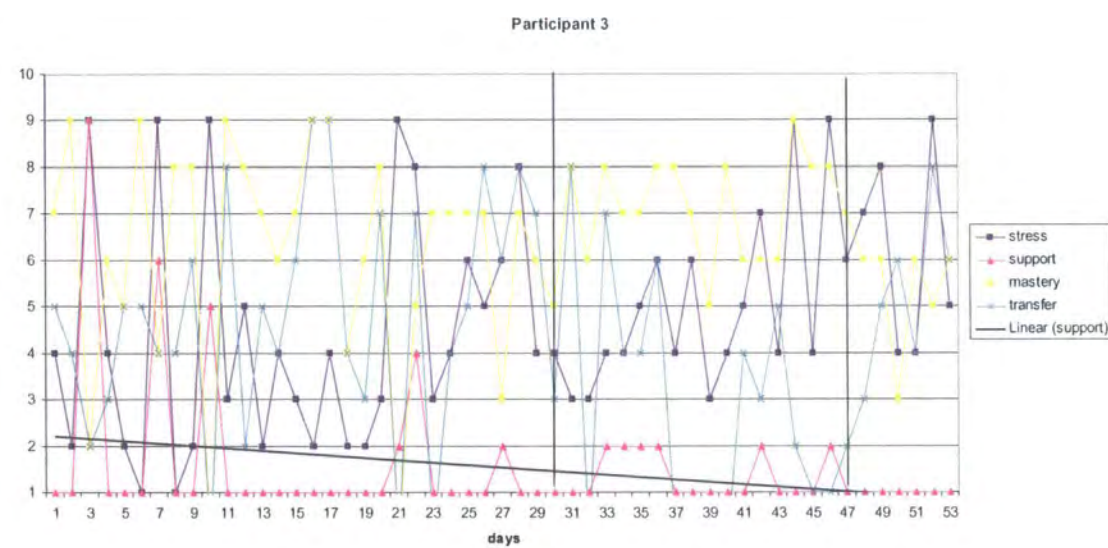
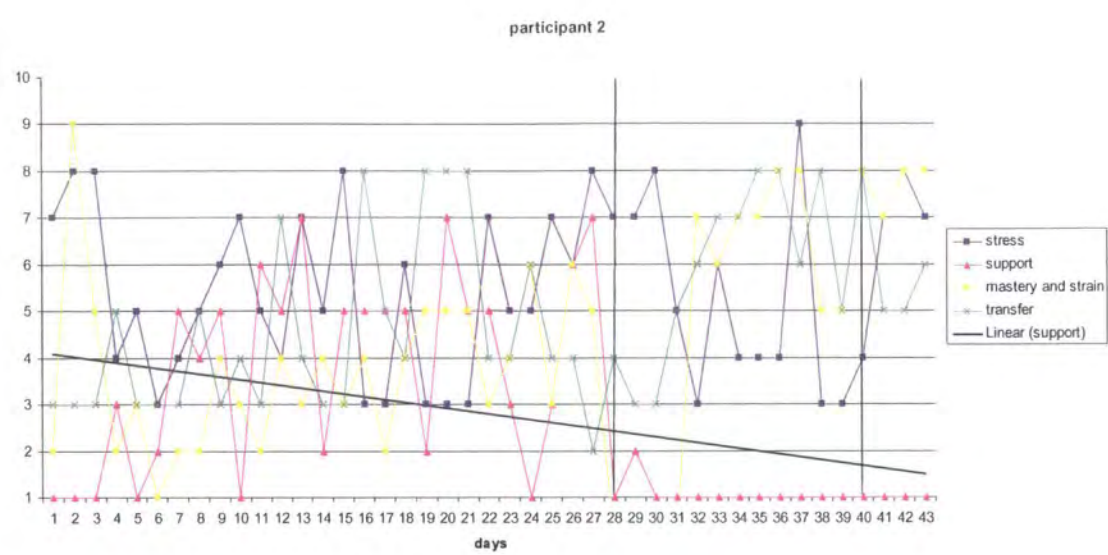
showed an increase, but the data are not stable, especially towards the end of the intervention and post-intervention phases.

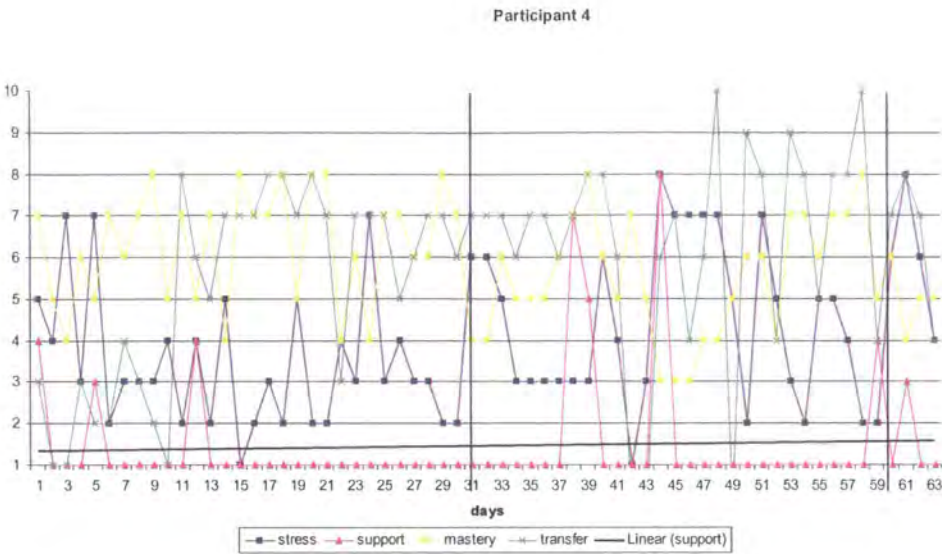
5.3.3.9 Support

‘Sought or found emotional support from loved ones, friends or professionals’ (Stone & Neal, 1984)

Figure 5-10 Support, stress, mastery and transfer during baseline, intervention and post intervention







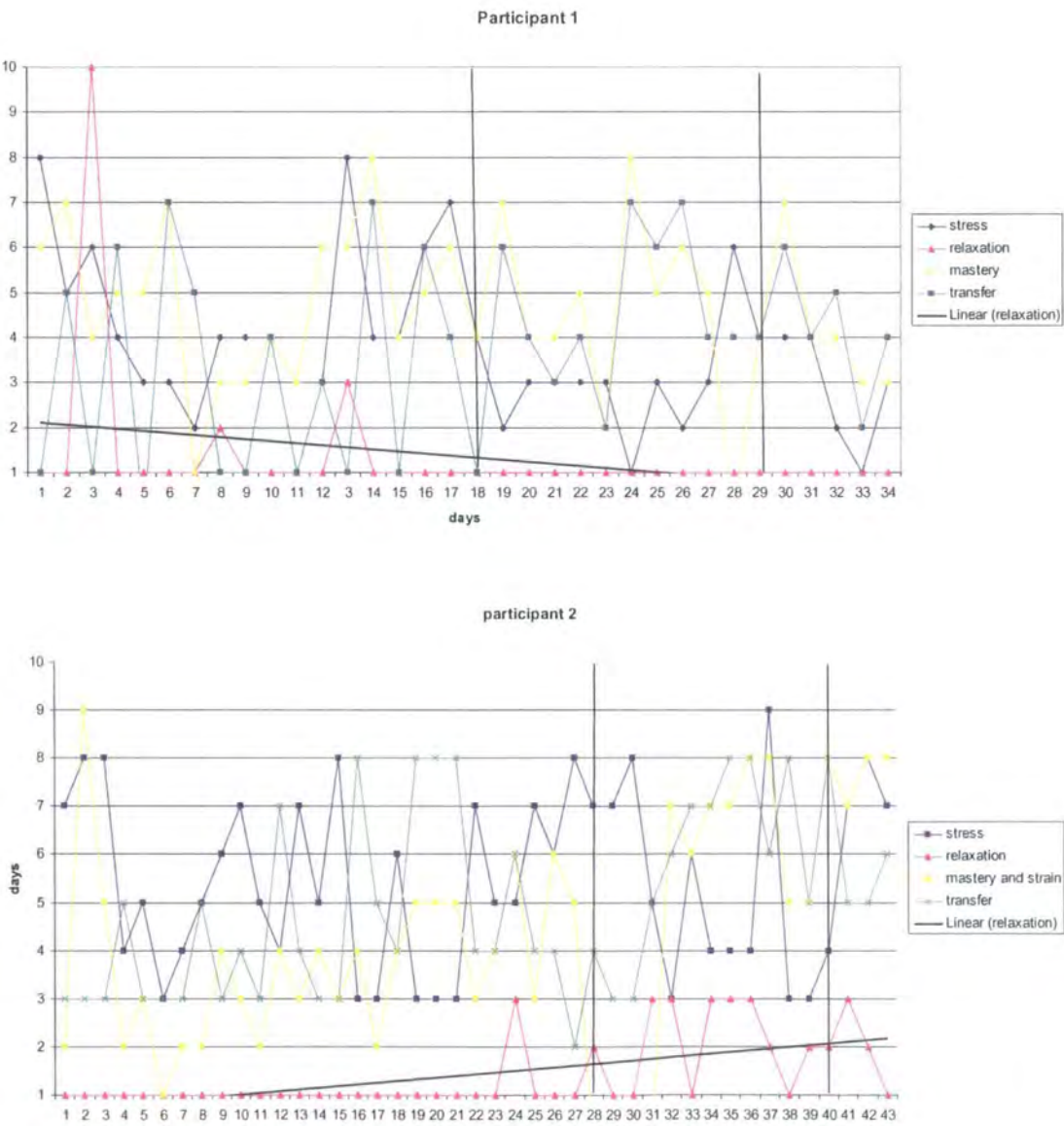
As evident from the charts above there are differences amongst the participants of the study. Participants 1 and 2 showed a stable use of support throughout the study, despite some peaks during the intervention phase in Participant 2 and an increase in the use of ‘support’ during the post-intervention phase. Participants 3 and 4 both showed a decrease in the use of ‘support’, although in Participant 3 scores decreased during the pre-intervention phase. Unfortunately, in this case it is difficult to conclude that changes were due to the intervention.

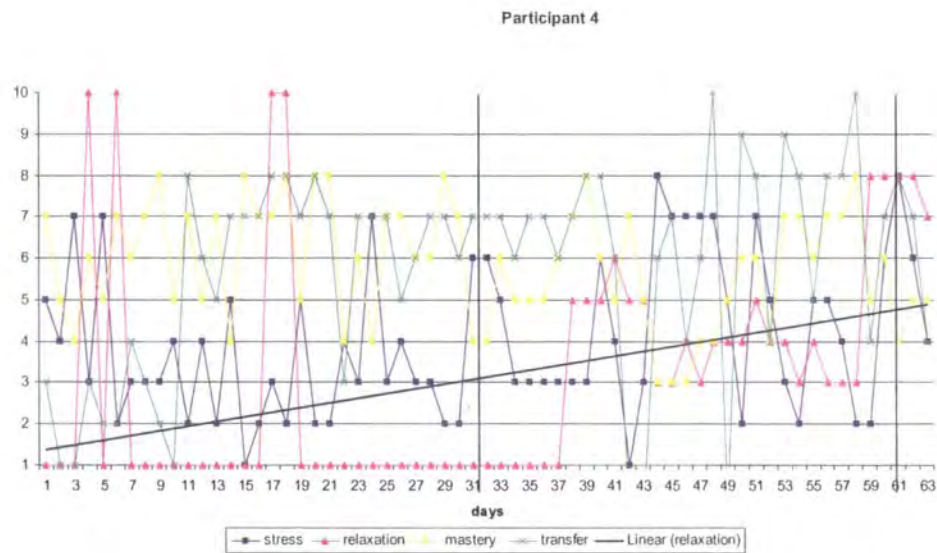
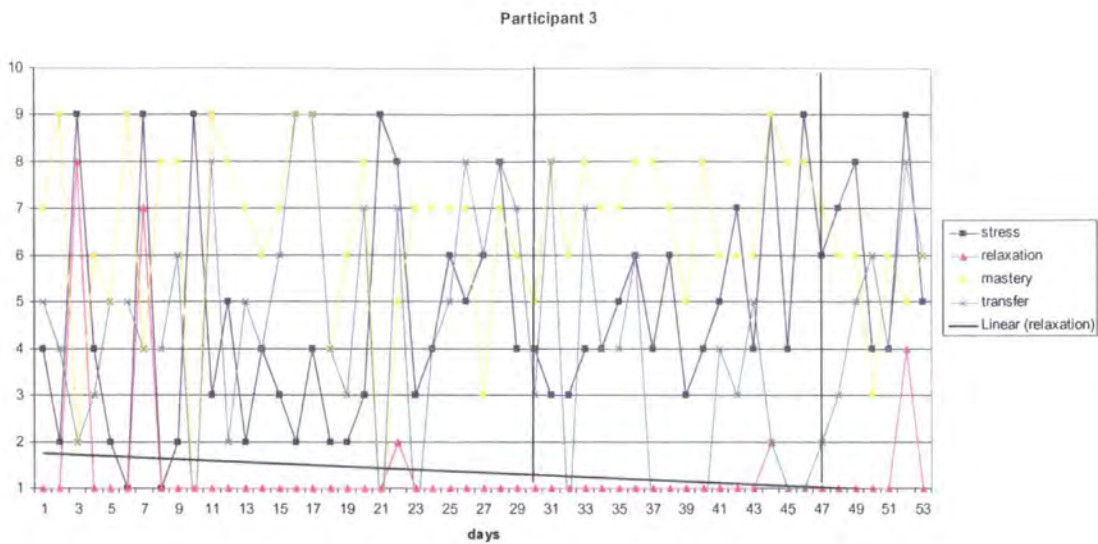


5.3.3.10 Relaxation

‘Did something with the explicit intent of relaxing’ (Stone & Neal, 1984).

Figure 5-11 Relaxation, stress, mastery and transfer during baseline, intervention and post intervention





All four participants showed some changes in the use of ‘relaxation’ (increase for Participants 2 and 4 and decrease for Participants 1 and 3), however these changes took place before the Revitalising Clinical Intervention was introduced.

In conclusion, the visual inspection of these charts did not lead to the expected result. It emerged a quite confusing picture and no effects of the extra RCS could be inferred.

From the comparison of the figures of the four participants, it cannot be assumed that changes were due to the intervention, especially because in some cases change happened before the intervention, or after several days. In general, no clear associations between coping, mastery and transfer were found.

However, consistent changes were reported for three of the coping strategies. As regards ‘action’ some change were reported in the cases of Participants 1 and 2 (decrease for Participant 1 and increase for Participant 2). The use of ‘catharsis’ increased in Participant 4 and decreased for Participants 1 and 2. Changes were also noted in the use of ‘distraction’ –(increase in Participant 4 and decrease in Participant 1.

Although there might be some individual changes in a multiple baseline design, to convincingly show that an intervention has been responsible for change there must be repeated demonstrations of changes in specific behaviours in the participants at the time the intervention is applied (Barlow & Hersen, 1984, p. 126). This is clearly not the case in this instance.

**5.3.4    The autoregression analysis**

In order to support findings from the visual inspection, I performed an autoregression analysis. The key variables in the statistical models derived for each of the coping mechanisms are shown in the four tables below. ‘AR’ denotes the autoregressive parameter. It takes values between -1 (indicating a strong negative association) and 1 (which gives very strong positive association); 0 gives no association. AR suggests

whether scores depend on previous scores. For example, a strong positive score with a statistical model probability  $<0.05$  indicates that the score depends strongly on previous scores, thus allowing the ability to make predictions of future values.

The ‘effect of the intervention’ is reported in the fourth column. This is equivalent to the overall mean score minus the mean in the intervention phase.<sup>1</sup>

Table 5-30 Participant 1: autoregression and effect of intervention

	Ar	p	Overall mean	effect of intervention	p
Distraction	-0.39	0.06	1.51	-0.05	$<0.23$
Redefinition	0.03	0.85	4.3	-1.03	$<0.14$
Action	0.1	0.5	5.9	-1.7	$<0.04$
Catharsis	-0.18	0.3	2.9	-1.4	$<0.05$
Acceptance	-0.02	0.88	1.7	-4	$<0.3$
Support	0.1	0.5	1.7	-0.06	$<0.9$
Relaxation	-0.1	0.5	1.6	-0.06	$<0.18$

The data presented above suggest that only the values for ‘distraction’ depend weakly on previous scores, thus not allowing the ability to predict future values of the series. This means that there is no statistical evidence of any trends, but a little of modest effects.

Table 5-31 Participant 2: autoregression and effect of intervention

	Ar	p	Overall mean	effect of intervention	p
Distraction	0.8	0.6	2.6	-1	$<0.001$
Redefinition	0.1	0.3	3.4	2.4	$<0.00$
Action	0	0.7	6.7	1.2	$<0.01$
Catharsis	0.3	0.03	3.9	-2	$<0.01$
Acceptance	0	0.7	6.4	0.9	$<0.2$
Support	0.1	0.5	3.6	-2.5	$<0.00$
Relaxation	0	0.8	1.1	0.9	$<0.00$

<sup>1</sup> ‘Religion’ was not reported, as none of the participants used it.

For Participant 2, none of the values of the eight coping strategies is a predictor of future behaviour. However, the RCS had a modest and statistically significant impact in all but one (acceptance) of the coping strategies. In particular, the intervention decreased the use of distraction, catharsis and support. Redefinition and action were the coping strategies used most often after the intervention. These have been defined as ‘problem solving’ strategies, and imply more effort from the individual; they also have more long-term effects.

Table 5-32 Participant 3: autoregression and effect of intervention values.

Participant 3	Ar	p	Overall mean	effect of intervention	p
Distraction	-0.1	0.4	1.8	-0.4	<0.1
Redefinition	0.1	0.3	1.9	-0.6	<0.09
Action	0	0.7	6	1.3	<0.01
Catharsis	-0.1	0.2	2.2	-0.1	<0.6
Acceptance	-0.1	0.2	2	-0.5	<0.1
Support	0.1	0.4	1.7	-0.4	<0.1
Relaxation	-0.8	0.5	1.4	-0.2	<0.3

For Participant 3, there is no evidence of trends, although, the intervention did have a small statistically significant effect on the ‘action’ strategy.

Table 5-33 Participant 4: autoregression and effect of intervention values.

Participant 4	Ar	p	Overall mean	effect of intervention	p
Distraction	0.5	0.00	2.2	4	<0.00
Redefinition	0	0.6	3.7	2.1	<0.00
Action	0.2	0.05	5.3	0.9	<0.1
Catharsis	0.5	0.00	1.3	5.5	<0.00
Acceptance	0.6	0.00	1.7	6.4	<0.00
Support	0	0.5	1.3	0.2	<0.5
Relaxation	0	0.04	2	2.6	<0.00

For Participant 4, none of the coping behaviours are good predictors of future behaviour. Furthermore, there are some quite strong and significant effects of the RCS, particularly

as regards catharsis and distraction, defined by Stone and Neal (1984) as emotion focused strategies.

#### 5.3.5 Conclusions

This study is an important attempt to test the Lazarus model and investigate the role of coping strategies in a real life situation. From the data it emerged that only one participant exhibited significant changes in behaviour, and no clear and stable associations emerged.

In the Chapter that follows, I will discuss the results of the three studies, their limitations and the contribution of the present investigation to the field of training and transfer.

## 6 DISCUSSION

In this chapter I will discuss the results in the light of existing research studies. The chapter starts with a general overview of the research investigation, and then discusses the results in more detail. The limitations of the investigation are acknowledged, and possibilities for further research proposed. Finally, implications for practice are considered.

### 6.1 Overview of the Results

This investigation was designed as a contribution to the study of training, CS and the problem of transferring newly learnt skills to practical work with clients from the learning environment to routine clinical work.

In recent years, the training of health and social care staff working in mental health services has been considered a priority and the Government's mental health policies have stated that MHPs should be trained to provide 'evidenced-based' interventions. However, although this is a welcome recognition of psychosocial methods, transfer of newly learnt skills to practice has been identified as being problematic.

The current literature has investigated the problem of training and its transfer, with different authors providing explanations both at the organisational and individual levels. Amongst individual characteristics, emotions have recently been recognised as playing an important role in the learning of new behaviours and in human performance. Having conducted a literature review, I identified the Lazarus model of emotions (1991, 2000) as

the most suitable to explain how emotions work in real life situations, such as training of MHP. This model therefore provided the theoretical background for the present research. This thesis aimed to develop a model that could describe the role of emotions in training and its transfer to the workplace, and to explore how it may be operationalised and applied. Subsequently, this investigation had three specific objectives and two underlying hypotheses. The work undertaken to achieve each of the three objectives was, for convenience, referred to as Study 1, 2 and 3 respectively. The first two studies consisted of an investigation into the suitability and operationalisation of the Lazarus model. The third study was a test of this model in a real-life situation. Overall, the three different objectives of the thesis were achieved, and the two hypotheses tested

The first objective was to check the suitability of the Lazarus model to describe the emotions experienced by MHPs when undergoing training and in their attempts to transfer their learning into practice. The first step into achieving this was to check whether emotions are indeed present in the experience of both training and transfer. Analysis of the interview transcripts confirmed that emotions were present in the training, supervision and transfer situations. The second step was to check whether the main variables of the Lazarus model (cognitive, motivational and relational) were present, thus providing some evidence of the suitability of the model. This was illustrated by the themes in the content analysis, which corresponded closely to variables of the Lazarus model. In particular, the content analysis demonstrated that the person-environment relationship variable is a mediator of the emotions reported, with 'empathy' being



mentioned several times, especially in connection to the relationship with the supervisor.

Lazarus (1991) however, did not see empathy as an emotion, stating that

‘If we define empathy as sharing another’s feelings, then it cannot be a single emotion because its response characteristics depend on the emotion manifested by the other person. [...] It is better to regard empathy as a capacity and a process rather than an emotional state. I prefer the concept of compassion as an emotion’(p.821).

Other authors are in agreement with this definition. For example, Hook and Bunce (2001) defined empathy as

‘the degree to which trainees felt the trainer understood their problems and difficulties. [...] This construct relates to the analytical and interpersonal skills the trainer possesses, rather than didactic teaching’ (p.439).

Therefore, in the present thesis ‘empathy’ has been considered as a process variable and part of the broader process of the ‘ relational’ aspect of emotions.

Regarding the analysis of the quantitative questions, of particular interest was that trainees reported that their perceived barriers to the transfer of their training had only a ‘moderate impact’ on their work with clients. This means that, even if they referred to some barriers to their transfer, they thought these were not hugely relevant. Furthermore, while the mentioned barriers were perceived as having little impact on transfer, they were nonetheless negatively correlated with the general success of applying measured by the

GQ. The trainees also perceived their success as being 'moderate'. This supports the idea that the perceived barriers had little influence on the implementation of the new skills when working with clients. By contrast, the supervisees (who had already undergone the PSI course) reported more success. This may be because they felt more competent and confident about their new skills, probably because they had more time to put them in practice. However, they reported some disappointment when the content of the supervision was strictly managerial. This confirms what illustrated by Turner (2000) and summarised in section 2.10.2, p.51 and is also in line with some of the social work education literature, (e.g. Brown & Keen, 2004). For example, Cooper and Rixon (2001) argued that

'A key benefit for the implementation of skills covered in supervision, involves line managers to refocus on the developmental and supportive aspects of supervision, instead of a narrow managerial approach' (p.701).

Sellars (2004) indicated that some of the advantages of CS are improved confidence and a feeling of well-being and support. Other authors argued that CS is regarded as a 'confidence builder' and a means of support and personal development and (Sloan *et al*, 2000, p.516).

This 'moderate' result is in line with similar studies. For example, Hook and Bunce (2001) conducted a study of the transfer of training. They assessed declarative knowledge soon after the course had ended and found the trainees had obtained poor scores. One of the possible reasons they suggested was that insufficient time had passed for trainees to

completely master the training material. This may be the case in the present study, where the transfer of training was assessed close to the course ending. Another possible explanation is that the teams within which the trainees worked were not prepared to change, or that appropriate supervision was not provided. For example, in an evaluation of training conducted by Carpenter *et al.* (2007), trainees who were attending a PSI course found their teams not particularly supportive. Furthermore, the CS they were receiving from their workplace supervisors was not adequate to their needs.

In addition to such situational barriers, the literature, (e.g. Warr & Downing, 2000) suggested that high levels of anxiety may be disruptive and interfere with cognitive processes such as learning.

However, in the present study some respondents reported high anxiety in learning but gave themselves good scores for the transfer of learning. One participant in particular repeatedly reported high levels of anxiety in connection to the relationship with the trainer, but then reported good levels of transfer. However, this participant is the only one who reported such high levels of anxiety. Interestingly, Lazarus's idea of emotions as a 'transactional process' includes the concept of appraisal of the external events. It would appear that each individual can elaborate the same event in different ways and then generate a particular emotion and transfer outcome. For example, an event that is appraised as stressful, such as a trainer's teaching style, might be appraised as a challenge, and lead to the experience of a particular emotion, finally leading to an adaptive coping strategy and successful transfer. In the case of the present study, it might

also be that although the individual experienced an extreme negative emotion, the coping strategy used was effective in reducing the disturbing effects of the anxiety. From the transcript of the interview it is not clear what kind of coping strategy this particular trainee used, however, it underlines the connections between coping and emotions.

Returning to the general results, all the respondents reported high levels of motivation, even those who had experienced negative emotions such as anger, or sadness. Motivation is an important factor that is closely linked with coping. According to Lazarus (1991), the right kind of coping strategy can lead to an individual becoming re-motivated after a failure, and thereby capable of concentrating effectively to provide good performance. He argued that ‘coping is a way to accomplish something, [...] and goals are implied’ (p.830). In the case of the present study, it might be that the trainee mentioned above, experienced high levels of anxiety and so used some avoidance mechanisms. This diverted his/her attention from the anxiety, and allowed the trainee to re-motivate him/herself. Two other respondents (who also described high levels of motivation) reported some strong negative feelings in connection to their transfer experience. However, they also reported having reacted to these feelings by using some active coping strategies. This supports the idea that motivation and coping are closely linked.

The objective of the second study was to measure the emotional responses of MHPs in a training programme and investigate whether these were associated with the extent to which they were able to implement their learning in practice. In order achieve this objective, I operationalised the Lazarus model through the construction of a questionnaire

(ATQ). To test the first hypothesis, (that emotions play an important role in learning and transfer) I correlated the results of the ATQ to a questionnaire measuring transfer of training (GQ).

Psychometric analysis of the ATQ verified the properties of the questionnaire. The motivational and the relational sub-scales had acceptable internal reliability and validity scores. However, the cognitive scale had low levels of internal consistency, thus indicating that further work needs to be done in order to operationalise the concept of cognition reliability. For example, improvements might be made in the wording of the items. In particular, item 20 (Regulating my feelings or general mood helps me to learn about PSI, & to transfer it to my clients (for example, improving how I feel by thinking positively or ‘dampening’ a more excitable mood by calming myself down), breaks some of the rules of question wording suggested by Oppenheim (1992, p.128). First of all, items should not be too long. Secondly, he advised the avoidance of double-barrelled items. This item contains two different constructs: learning and transfer. Thirdly, simple words should be used and jargon avoided: do people know the difference between *mood* and *feelings*? Another possibility as to why the scale had low internal consistency is that it had low face validity. People filling in a questionnaire about their emotions might be surprised to find questions on their cognitive processes, they might feel confused, and hence find it difficult to provide the relevant answers. Finally, considering that half of the respondents failed to complete the last section of the questionnaire, it may be that it was too long.

Regarding the test-retest reliability scores, only two (cognitive and motivational) of the five scales of the ATQ yielded significant correlations. However, it might be the case that this kind of reliability test is not appropriate when measuring mood and emotions. Some authors, for example Pallant (2000) and Nunnally (1978) argued that, when measuring test-retest reliability, the nature of the construct that the scale is measuring should be taken into account. For example, mood states or emotions are not likely to remain stable, and therefore the test-retest correlations of a scale designed to measure these are likely to be low. Alternatives to test-retest reliability are not suggested, but a good idea might be to use split-half reliability. This is a measure of consistency where the test is split in two and the scores for each half are compared with each other. If the test is consistent it is most likely reliably measuring the construct in question.

In the present study, the significant bivariate correlations highlighted that the relational scales correlated significantly with the generalisation score, which included two items underlying support. However, some research on behavioural learning strategies, investigated the links between interpersonal help seeking, (defined as the procedure to obtain help from other people, Warr & Downing, 2000, p.312) and learning outcomes. Karabenick and Knapp (as cited in Warr & Downing, 2000) reported significant negative correlations in a series of studies that investigated interpersonal help-seeking strategies in college students. These were found to be linked to a greater perceived need for help, so that those students most seeking help felt that they were in special need of assistance. This would imply that more help-seeking may in practice reflect lower ability. However, further studies conducted with samples of adult learners attending professional courses,

highlighted the importance of finding help and support from fellow trainees, the trainer and the general work context. For example, Colquitt *et al.* (2000) showed that support (both managerial and peer support) had a significant impact on transfer. They summarised a series of studies that reported how both managerial and peer support can help trainees, particularly in transferring learned skills to the work setting. For example, Fecteau *et al.* (1995) conducted a study on 967 managers in departments within state government agencies. Their results showed a positive link between manager support and motivation to learn.

The scores on the different items of the ATQ suggested that the motivational and relational aspects of learning were seen as important mediating variables in the process of learning. The negative emotions in transfer section of the questionnaire yielded lower scores than the negative emotions in training section. This indicates that individuals were experiencing moderate levels of negative emotions.

Overall, on the basis of these findings, the hypothesis that emotions play an important role in both the acquisition and the transfer of new skills was partially confirmed. Scores from the ATQ indicated that emotions are indeed present in learning and transfer, thus also supporting the interview results, however the correlations highlighted only part of the links.

Due to the small sample size, however, the exact nature of the relationship between positive and negative emotions and transfer could not be investigated. A multiple

regression analysis would have been useful to clarify this relationship, but one of the assumptions to be met when using multiple regression, is to have at least 15 participants per variable (Dancey & Reidy, 2002). Unfortunately, only 46 participants correctly filled in the 'before' and 'after' generalisation item, so this analysis was not possible. Dancey and Reidy (2002) stated that if not using enough participants, the results will be probably not be generalisable, and conclusions invalid.

The third objective was to test an intervention based on the assumptions of the Lazarus model, and to clarify the role of coping. For the whole duration of the study, regular feedback on the completion of the diary was provided. Particular importance was given to the discussion of any difficulties of implementation experienced by supervisees in applying PSI techniques with clients. Supervisees were also encouraged to use their coping strategies, in order to reduce stress and anxiety and promote a sense of mastery and positive emotions (and hence to work better with their clients).

From the visual inspection of the data, no clear associations emerged between the RCS, transfer, coping, stress and emotions, and occasionally the behaviour changed before the implementation of the RCS. Unfortunately, the exact dates of when the RCS session occurred were not available. It would have been useful to check whether any effect was present at least on the day when the intervention took place.

According to the design of Study 3, in order to assume that the intervention was effective, change should have had happened in all four participants, or in at least three of them. The autoregression analysis showed some strong effects of the RCS in Participant 4 for five of



the eight coping strategies. Of course, these data cannot be generalised, but it could be helpful for future studies. The strongest effects of the intervention were reported in distraction, acceptance and catharsis, which have been defined as maladaptive coping strategies (Mooss, 1997). However, in accordance with his appraisal theories, Lazarus (1991) argued that deciding whether coping strategies are effective or not requires an assessment of the interactions of situational factors, for example the nature of the stressful event, and personal factors, such as personality and beliefs about coping resources and their effectiveness. Zeidner & Saklofske (1996) stated that one cannot distinguish between adaptive and maladaptive coping strategies, 'rather the concern must be for whom and under what circumstances a particular coping mode has adaptive consequences' (1996, p.506).

A better categorisation of coping might therefore be that of problem-focused (PFC) and emotion-focused (EFC) coping. PFC seems to have more positive effects on long-term psychological outcomes, while EFC may help in maintaining emotional balance (Lazarus, 2000). In particular, EFC might be useful at times because it gives the person psychological breathing space and an opportunity to escape from the constant pressures of the stressful situation (Carver *et al.*, 1989). For example, when dealing with a difficult situation during a session with a client, the supervisee may find it beneficial to accept failure, or to distract themselves from the problem, maybe to focus on it again later. This strategy might be useful to prevent anxiety, and concentration failure.

Although the coping strategies improved overall, from the visual inspection it does not look like there are associations with transfer, mastery or stress. This result, therefore, only suggested that the intervention was effective in one participant. The data are not therefore generalisable, and indeed it is possible that the increased use of the coping strategies by this individual might be due to factors external to the experiment.

In summary, the theory about coping strategies as mediators of emotions and transfer was indicated in the interviews with practitioners, but was not evident in the daily monitoring of emotions and practice in Study 3. Therefore, the hypothesis that the use of coping mechanism facilitates the process of learning and its transfer was not confirmed. Moreover, as a consequence of the lack of success of the intervention, no clear relationships emerged.

There may be a number of reasons why clear effects of the intervention were not obtained. Firstly, the instrument might not be sufficiently sensitive to pick up changes in individual ratings. Although the instrument was checked for its psychometric properties, piloting was conducted and a discussion meeting arranged with the participants, there may be areas for improvement. For example, the daily diary might be too long and difficult to complete, especially on a daily base.

Secondly, it is possible that respondents did not fill in the diary at the end of each working day as planned, but at other times. For example, they might have been very busy and only completed the diary retrospectively, for a number of days at a time. If so,

this would make their responses less reliable. Future research should try to keep the questionnaire shorter and seek ways to gather data regularly, for example daily by telephone.

Thirdly, it might be that the supervisor did not properly deliver the RCS. Although a consultant clinical psychologist had contact with the supervisor, perhaps the supervisor could have been better trained and supported. For example, the psychologist might have observed the supervision sessions directly and provided live supervision during the meeting between the trainee and the trainee's supervisor. Alternatively, the RCS could have been recorded and the recordings used in meetings with the supervisor, where the psychologist could have reviewed them and given corrective feedback.

The fourth possibility is that the effects of this intervention are not immediate and needed time to be consolidated by the supervisees. Following the logic of what was suggested by Hook and Bunce (2000) for transfer of training, it might be that people were still learning the new coping strategies at the time of the assessment. It might also be that the supervisees needed more sessions of the RCS. As described in the procedure (section 4.3.1.1), they had a maximum of five sessions over a period of a month, which might not have been enough to learn the new skills.

By contrast, Salas and Cannon-Bowers (2001) identified learning decay (the delay within learning and any use of the newly learnt skills in the job) as a potential issue related to the application of learning. However, in all three of the present studies, transfer rates were

assessed soon after the training or CS, and the studies were conducted within the period of attendance on the training courses or when the participants were receiving CS

A fifth possibility is that the lived experience of work is very complex, and involves not only the individuals with their specific characteristics, but also their relationships with peers and managers/employers, as well as the wider organisational environment. These themes all emerged from the first two studies, and are well acknowledged in the literature. According to Milne *et al.* (2000a), transfer of training requires careful attention to the work environment. Goldstein (1993) suggested that transfer requires an appropriate organisational climate, and managerial support, as described in Chapter 2, and in the present chapter (p.217). Repper (2000) also highlighted how lack of support and understanding in the workplace is a barrier to the application of learning. Brown and Keen (2004) studied the completion and management of the process of post qualifying studies in social work (the Post-Qualifying Social Work Part 1 Award), and identified the lack of an educational role for managers as an area in need of more attention. A picture emerged where trainees, managers/employers and educators prioritise different knowledge bases and skills.

In a related area of post-qualifying education for social workers, researchers (Brown *et al.*, 1989; Berryman, 1993) stated that individual attitudes and engagement of social workers in post qualifying education, continuing professional development and workplace learning are influenced by the culture of the team to which they belong and the nature of the supervisory relationship that links them with the organisation.

In Study 3, the wider organisational environment where transfer was taking place was not explored and so, even though a rigorous experimental design was used, it remains possible that ‘third variables’ account for the results when measuring transfer of learning (Carpenter *et al.*, 2007, p.20).

These ideas suggest that, when considering the results of Study 3, more attention should be given to the role played by the work/organisational environment when attempting to apply new skills. This is commonly reported in the wider research literature, where it is established that such innovations (e.g. implementation of new clinical skills) will only be sustained with organisational support (Corrigan *et al.*, 1997). For example, Milne *et al.* (2006) applied a model of innovation at work (West & Farr, 1989) described in section 2.6, and found that organisational factors, for example administrative managerial styles and insufficient resources, hindered the introduction of innovations, such as new methods of working, for example using PSI.

Finally, the sixth possibility is that there are no relationships between coping, emotions and transfer. An experimental study from Honey *et al.* (2002), on post-natal depression evaluated the effects of an eight-week intervention based on (amongst other things) a training course on coping strategies. The results showed an improvement in mood, but no change in the use of coping strategies. The authors concluded that, ‘emotions, appraisals and coping are independent processes’ (p 408). However, they also stated that a brief intervention is not sufficient to induce positive changes in coping behaviours. In relation to Study 3, Honey’s research (2002) may support the idea that there is actually no

relationship between the variables assessed. However, Honey (2002) made no distinction between the concept of mood and emotions, and assumed that the lack of associations between mood and coping implies there are no associations between emotions and coping. An emotion is considered to be brief and event-specific, whereas mood is broader and lasts longer. Also, while emotions are triggered by events that occur quickly and without warning, mood may occur following an event that is perceived as happening over a longer period of time (Ekman & Davidson, 1994). For this reason, it might be that, to find associations between coping and mood, more time is needed and more complicated analysis techniques used.

However, results from the interviews conducted in the first study of the present research supported the idea that a link exists between coping, emotions and transfer. Consequently, it appears that further investigation is needed, taking into consideration the six points described above.

In conclusion, the extended Lazarus model of emotions proved to be a suitable model to describe emotions experienced by MHPs who are in a learning situation and are transferring new skills with their clients. The themes that emerged from the content analysis corresponded to the variables and the dynamics of the model as described by Lazarus (1991, 2000). Correlations between the quantitative questions of the interviews and the GQ helped to clarify some aspects of the problem. Once the Lazarus model had proven to be suitable to describe emotions in learning and transfer, the operationalisation of the model through a questionnaire (ATQ) allowed to measure emotions in training and

transfer. Descriptive statistical analysis of the items of the ATQ highlighted how the different emotions and the variables of the model (the relational and motivational variables only were considered, as the cognitive scale did not achieve satisfactory reliability scores) are present in training and transfer. Analysis of the data obtained from the GQ partially clarified the links between emotions, training and transfer. Therefore, the first hypothesis of the study, that emotion play an important role on the acquisition of learning and the transfer of new skills was tested and partially confirmed through the second study. Due to a number of factors that I have discussed above, the intervention based on the extended Lazarus model had no effects, and the role of coping could not be clarified. The second hypothesis of the study, that the use of coping strategies facilitates the process of learning and its transfer, could not be verified.

The present investigation also presented a number of limitations, which I will comment in the paragraph that follows.

## **6.2 Methodological issues**

I will now discuss in more detail the limitations of the present study.

1. The data are based on self-reports. This might imply that some people are not aware of the emotions they experience, or of the coping strategy they adopt. The use of interviews could provide a more in-depth account. Other respondents may present themselves in what they consider a pleasant manner, although the likelihood of impression management is reduced by the anonymity of the data.

2. There were problems with the correct completion of the ATQ and the DCD. It may be that these instruments were too long and required different tasks. For example, some parts of the daily diary required an evaluation of items using a scale from 1 to 10, while another section simply required that boxes were ticked. The ATQ required respondents to rate some items twice, the first time in connection to transfer and the second in connection to training.
3. For the first two studies, training outcomes were measured without the use of a control group, so the findings are not clearly attributable to the training course. Alliger *et al.* (1997) suggested alternative methods to assess training. For example, he suggested recording direct observations of training intervention, or using methods employed in psychotherapy, such as the events paradigm. Here, the client identifies key episodes and the contribution of these episodes to the change process is studied. In the training situation, this would be useful to identify the difficulties that trainees encounter during the sessions and to clarify the relationship between the perceived difficulty of the training session and learning outcomes.
4. As regards the interview, for practical reasons some interviews were conducted by telephone and others face to face, thus creating a slight difference in the quality of the transcripts.



5. The samples were opportunity rather than randomly selected, and all members of the samples were volunteers. Consequently, it is not possible to generalise the results to the population of mental health trainees.
6. The samples were too small in size for some of the statistical analyses, such as regression analysis, which would have been desirable in order to identify any causal relationships.
7. The wider organisational context in which training and clinical supervision takes place was not explored. Students' relationships with the managers, trainers and supervisors for example, could be investigated in future research through the use of questionnaires or interviews.

### **6.3 Implication for practice**

In this section, I will comment on the possible implications of this investigation for professional practice. I do so taking into consideration the results obtained, and the limitations of the research described above.

The main contribution of the present research is the validation and application of the extended Lazarus model in a training and transfer context. I argue that the emotional dimension needs to be considered when conducting research on training and clinical supervision. The assumptions underlying the extended Lazarus model are that the learning process and its outcomes are multidimensional. Consequently, progress in

training research requires a multidimensional perspective which includes not only changes in knowledge, skills and abilities (Goldstein, 1993) but also in the emotional domain. By adopting a multidimensional approach that features emotions as a transactional process, as described in the extended Lazarus model, issues of training outcomes are necessarily broader than those described for example in the widely adopted Kirkpatrick's model of training evaluation (1967) (described in Chapter 2). The extended Lazarus' model could then be used as a theoretical framework for assessing training effectiveness (Lombardo, 2004). An examination of multiple training outcomes distinguishes between training evaluation (tailored to check whether students have achieved learning outcomes) and training effectiveness (Hook & Bunce, 2001). Training effectiveness aims to establish whether training outcomes have been achieved by analysing the trainee's individual characteristics and the organisational factors. Amongst the individual characteristics, on the basis of the results obtained, I argue that the emotional impact should be included, taking into consideration the cognitive, relational and motivational variables as mediating factors.

However, despite the fact that the extended Lazarus model was successfully developed, its implementation in a real life situation still needs to be tested. The results of the third study can be partially attributed to the methodological limitations described on page 238, but also to the impact that environmental factors have on the individual (234-236). Lazarus argued that emotions are 'reactions to ongoing relationships with the environment, most often interpersonal or social' (2000, p.230). In the specific context of learning and transfer in the field of mental health, for example, managers /employers,

students prioritise different knowledge-bases and skills. Therefore, in considering a multidimensional approach of training and transfer which includes emotions as an important variable, the wider environment and organisational context should be accounted and investigated more carefully.

Overall, although I have introduced a new model to the study of training for MHP and transfer, the potential limitations that I have discussed above need to be examined more carefully in future research.

Furthermore, the study results could help to improve the transfer of skills learned in training to practice and also increase the benefits of CS. From one side, it would seem advisable for trainers and supervisors to pay more attention to the emotions experienced by trainees and supervisees and not look solely at the technical content. On the other side, trainees and supervisees could be more aware of their emotional responses, and with the support of the trainer or supervisor could find ways of coping and overcoming emotions that interfere with their learning processes. These outcomes would improve the cost-effectiveness of mental health training, and benefit the clients.

Training, CS and transfer can be stressful events that can activate emotions, that have consequences for performance, both in terms of learning and in transferring skills to the job. The main mechanism is the interference with attention and concentration. A second mechanism is the lowering of motivation, which can lead trainees and supervisees to give up when they have been unsuccessful. In general, it looks as if the use of coping

strategies when facing stressful situations can lead trainees and supervisees to re-motivate themselves and then re-focus on their aims. What trainers and supervisors should do is to encourage constructive forms of thought, in order to facilitate coping. However, Lazarus (2000) stated that 'even positive judgements can have negative consequences for performance'. For example, trainees who are doing well in applying their skills with clients may feel self-congratulatory about how they are doing, and so reduce their level of commitment to the course. The implication here is that trainers and supervisors have to be careful to remember that 'negative thinking is not always damaging and positive thinking does not always facilitate performance' (p.237).

A further implication of the model is the importance of the awareness of divergent perceptions and appraisal mechanisms, both between and within people. Trainees and supervisees should be aware that goals, commitments and beliefs vary, and that what is salient and noticed in the environment will also vary.

At a higher level, organisations can influence emotions and coping processes through their values and practice, in other words through their organisational culture. This culture might contribute to emotions by influencing the relational meaning (Lazarus, 1991) that a trainee or a supervisee builds up daily. For example, one norm of behaviour in a particular organisational culture might be to promote support from managers. Employer's should support employees in re-structuring the working day to take into account the homework that has to be done for a particular training course as trainees often complain about the fact that they have to do course work in their own time.

In conclusion, what has to be taken into consideration at all levels of the relevant work system, is the knowledge that a particular emotion has been aroused and to understand its dynamics. This might be beneficial to understanding of what is going on, and how to manage it. If a tutor's behaviour generates anxiety in some individuals, it might be that some trainees cope with this emotion and others may not. It is important therefore to diagnose the causes of an emotion in order to manage its consequences effectively. In this case, the tutor's behaviour may be corrected, or the supervisor may help the supervisees to adapt successfully.

It would also be useful to evaluate the contribution made by other aspects of people's lives, such as family or health-related problems. The participants in the present study mentioned that an understanding of these aspects was particularly beneficial. However, it should always be kept in mind that an emotion is the combination of cognitive-motivational and relational constructions about an event, and that people differ widely in their reactions to events.

In Chapter three a list of emotions and their definitions according to Lazarus was presented. He also developed theories about the arousal and regulation of each emotion, which are used in psychotherapy to help to understand what is happening to dysfunctional and emotionally distressed individuals (Lazarus 1989, 1991). His model might also be employed in the field of training, supervision and transfer and could be useful for understanding what is happening to individuals in this context, for example when they are struggling to perform at desired levels. It could also to help them benefit

from the training and supervision they receiving, and by doing so improve the quality of care.

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**Appendix 1 Interview consent form (trainees)**

**Affect and Training Interview**

The research currently being completed is part of a study approved by the Gateshead R+D committee & supported by your key managers. This part of the research is based on an interview, designed to investigate the role of emotions in the learning process and in the application of the skills learnt to the workplace. If you choose to take part you will be given a private, one to one, interview which should take approximately 30 minutes. It will focus on your experience of the PSI training programme. The information that you provide will be extremely useful to us & hopefully also to the PSI initiative in Gateshead (we will feedback the results). Any information you choose to provide will be totally confidential and you would be free to stop the interview at any time if you do not wish to continue.

If you are willing to participate the interview, please fill in the consent form below, so we can contact you to arrange an appropriate time when we could visit or phone you. Any help you can provide would be greatly appreciated and feedback from the research will be provided, in terms of the general findings (i.e. no individual will be identified).

December 17<sup>th</sup> 2001 Derek Milne, Chiara Lombardo Centre for Applied Psychology,

Please tick one:

I would be willing to take part in the interview ☐

I would prefer not to take part in the interview ☐

Name .....

Work phone number .....

**Appendix 2 Interview consent form (supervisees)**

**CONSENT FORM FOR AN ADULT TO TAKE PART IN RESEARCH**

NAME OF THE RESEARCH PROJECT: REVITALISING CLINICAL SUPERVISION IN MDT'S
Name of the Researchers: Derek Milne, Chiara Lombardo
Name of Participant: _____

**NOTE OF EXPLANATION**

**The aims of this study are:**

- To clarify current practice in relation to clinical supervision and the views of participants on what works in relation to supervision;
- To clarify the structural resources and contingencies that influence good supervision practice (including how key players - managers, supervisors and clinicians – formulate the current situation). In particular, attention will be given to how individuals manage the available resource and how this relates to realistic goals and to “informal” opportunities for clinical supervision;
- To seek and summarise suggestions for enhancing and revitalising clinical supervision;
- To pilot an appropriate intervention (such as supervision groups or workshops), to include evaluation of same.

**Project Design**

The general approach would be the one of “participative action research”, including a small project steering group with representation from all the stakeholder groups. The research design would be a mixed one, including: a) descriptive information, in relation to the first three aims; b) some inferential, between-group analysis, in relation to the pilot

quasi-experimental evaluation of a promising method of facilitating clinical supervision; & c) a small case series (N=1) design, with 3-4 participants would provide useful information in relation to how supervision impacts on clinical practice. The “daily coping” methodology was thought to be a promising approach, allowing to analyses how N=3-4 individuals mediate the organisational structural factors by their own personal coping strategies, so as to maximise the appropriate transfer of their supervised practice to their clients. A multiple baseline design across these 3+ participants would be employed. This would be the “experimental” (rigorous) aspect of the project.

### **Procedure**

It was assumed that semi-structured interviews, to be held with individual managers, supervisors and clinicians (supervisees), would be the most appropriate way to gather the relevant data as regard the first three objectives. In terms of the pilot intervention, data would be collected as appropriate (for example, in the case of a group supervision scheme, assessments of the group process, the appropriateness of the content addressed within the group, and the outcomes achieved would be administered to all group members). In addition, some assessment of a relevant aspect of competence (especially knowledge) would be administered before and after the group. If readily possible, a control group or double baseline condition would be added, to allow interpretation of the above data.

The content of any such pilot intervention would reflect the information gathered in relation to the first three objectives, especially the emerging information formulation of the current use of clinical supervision. These formulations would be based on the transactional stress coping model. According to this model, we would expect



interviewees (managers, supervisors and clinicians) to perceive supervision as stressful, but that considerable variability in the effectiveness of this supervision would be reported, as a function of the personal coping strategies of those involved and the organisational support and “climate”. This model would be an N=1 case series analysis, involving 3-4 supervisees in order to try to clarify how they manage to transfer their supervised practice to their clients.

I consent to take part in this research project.  
I understand that the research is designed to add knowledge.

I have read the note of explanation about the study above and I have had time to think about it.

I have been told that I can withdraw my consent at any stage without giving reason and without prejudice to my treatment/training.

I have been given a copy of this Consent Form.

Signed..... Date.....

I can confirm that I have explained to the participant the nature of this study, and have given adequate time to answer any questions concerning it.

Signed:.....Date.....

Name (in capitals):.....

Post:.....

FEEDBACK

If you would like to receive feedback on the results, please write your address below.

**Appendix 3 Demographic questionnaire**

**Instructions:** For this study some basic background information is needed about you. All these details will remain anonymous, and will only be used as part of an overall summary of information related to all of the delegates.

GENDER (CIRCLE ONE)	MALE	FEMALE
Age (in years)		
Job title		
Qualifications		
Length of time worked in this or a similar job		
Date when your PSI training started      /      /		
Length of time you have received Clinical Supervision		

Today's date .....

**Appendix 4 Interview schedule (trainees)**

**COLLABORATIVE PROJECT BETWEEN THE UNIVERSITY OF  
NEWCASTLE AND GATESHEAD NHS TRUST**

The aim of this research is to establish whether emotions are an important factor in the learning process and in the applying of that knowledge to the work place. Your responses will be totally confidential and the interview should last no longer than 30 minutes. If there is anything you do not understand or have any questions please do not hesitate to ask. If you would like to receive feedback about this research please ask and we will be happy to let you know. You are free to stop the interview at any time you wish. Thank you for your time.

1. How would you describe the PSI Training? i.e. If someone else asked you to describe the training, what would you say about it? (E.g. learning environment; attitudes to PSI, support, usefulness of the training etc.)

.....

.....

- 1b) How would you rate the PSI training program overall?

1	2	3	4	5
Highly negative	slightly negative	in between	slightly positive	highly positive

2. How successful you think you were in applying the PSI skills to the work place? (e .g. ease of application, usefulness of the training at work etc.)

.....

.....

2b) How would you rate the general success of applying the PSI training to the workplace?

1	2	3	4	5
highly unsuccessful	slightly unsuccessful	in between	slightly successful	highly successful

PART 2

3. Was there anything in the PSI training program itself that limited your learning in the classroom? ( i.e. barriers- management/colleague support, environment, motivation, trainer etc)

.....

.....

3b) To what extent did this limit the success of your training experience?

1	2	3	4	5
not at a all a barrier to learning	slightly limited the success	moderately limited the success	significantly limited the success	very significantly the success

4. What do you think made it difficult to use the PSI training skills with your clients?  
(E.g. management/colleague support, work environment, motivation etc)

.....

.....

4b) To what extent did this limit the success of using the PSI skills you learnt with your clients?

1	2	3	4	5
not at a all a barrier to learning	slightly limited the success	moderately limited the success	significantly limited the success	very significantly the success

5. What do you think improved the success of the PSI training programme/course?

.....

.....

5b) To what extent did this contribute to the success of your training?

1	2	3	4	5
not at a all	slightly contributed to the success	moderately contributed to the success	significantly contributed to the success	very significantly contributed to the success

6. What do you think improved the success of the PSI training in the workplace?

.....

.....

6b) To what extent did this contribute to the success of using your PSI training to clients?

1	2	3	4	5
not at a all	slightly contributed to the success	moderately contributed to the success	significantly contributed to the success	very significantly contributed to the success

7. Taking into account what you have said about barriers and boosters, to what extent  
have you felt able to:

a) Learn (circle)

b) Transfer (cross)

7 (a) To what extent have you felt able to gain confidence from your supervision sessions (in transferring)?

1	2	3	4	5
not at a all confident	slightly confident	in between confident	fairly confident	highly confident

7. (b) To what extent did you feel you increased your competence through supervision?

1	2	3	4	5
not at a all increased	slightly increased	don't know increased	fairly increased	highly increased

8. Of the events that occurred during the PSI training program, which ones do you feel were the most significant emotionally (positive or negative)?

.....  
What was the most significant emotional event (positive or negative) that occurred when applying PSI in the work place?  
.....  
.....

9. Would you like to add any other comments before we finish the interview? In particular, is there anything else you would like to say about the emotional aspect of the PSI training/use in the workplace?



**Appendix 5 Interview schedule (supervisees)**

COLLABORATIVE PROJECT BETWEEN THE UNIVERSITIES OF DURHAM AND  
NEWCASTLE AND GATESHEAD NHS TRUST

Revitalizing Supervision Interview

The aim of this research is to clarify current clinical supervision practice and its effectiveness and to reflect breadth of CPS methods; 'mapping the landscape' of supervision. This will be related to the organizational context. Your responses will be totally confidential and the interview should last no longer than 60 minutes. If there is anything you do not understand or have any questions please do not hesitate to ask. If you would like to receive feedback about this research please ask and we will be happy to let you know the findings. You are free to stop the interview at any time if you wish. Thank you for your time.

1. How would you describe your supervision session in your own words? i.e. If someone else asked you to describe the supervision, what would you say about it?  
(e.g. learning environment; your attitudes, support, usefulness etc.)

a)SPONTANEOUS:.....

b)PROMTED:.....

- 1b) How would you rate the supervision experience overall?

1	2	3	4	5
not valued	slightly negative	in between	slightly positive	highly positive

2. How successful you think you were in applying the skills that you discussed with our supervisor to the work place? (e .g. ease of application, competence, effectiveness etc.)

a)SPONTANEOUS:.....

b)PROMTED:.....

2b) How would you rate the general success of applying the clinical skills that you discussed in supervision to the workplace?

1	2	3	4	5
highly unsuccessful	slightly unsuccessful	in between	slightly successful	highly successful

Part 2

3. Was there anything during the clinical supervision session itself that limited your learning? ( i.e. barriers to learning - (e.g. lack of supervision skills), environment (e.g. age, ...size) motivation)

a)SPONTANEOUS:.....

b)PROMTED:.....

3b) To what extent did this limit the success of your supervision learning experience?

1	2	3	4	5
not at a all a barrier to learning	slightly limited the success	moderately limited the success	significantly limited the success	very significantly the success

4. Was there anything that made it difficult to apply the skills covered in supervision to your workplace? (E.g. management/colleague support, work environment, motivation etc i.e. *affecting the transfer of my learning*)

a)SPONTANEOUS:.....

b)PROMTED:.....

4b) To what extent did this limit the success of using the skills you learnt with your supervisor in the workplace?

1	2	3	4	5
not at a all a barrier to learning	slightly limited the success	moderately limited the success	significantly limited the success	very significantly the success

5. What do you think improved the success of your supervision sessions (facilitating your learning)?

a)SPONTANEOUS:.....

b)PROMTED:.....

5b) To what extent did this contribute to the success of your supervision?

1	2	3	4	5
not at a all	slightly contributed to the success	moderately contributed to the success	significantly contributed to the success	very significantly contributed to the success

6. What do you think about the supervision sessions improved your skills with your clients? (i.e. helped you to transfer material from supervision to your routine work)

a)SPONTANEOUS:.....

b)PROMTED:.....

6b) To what extent did this factor contribute to the success of using supervision skills with clients?

1	2	3	4	5
not at a all	slightly contributed to the success	moderately contributed to the success	significantly contributed to the success	very significantly contributed to the success

7. To what extent have you felt able to gain confidence from your supervision sessions (in transferring)?

1	2	3	4	5
not at a all confident	slightly confident	in between confident	fairly confident	highly confident

7. (b) To what extent did you feel you increased your competence through supervision?

1	2	3	4	5
not at a all increased	slightly increased	don't know increased	fairly increased	highly increased

7. (c) To what extent did you feel you increased your competence in your clinical work as a result of the

1	2	3	4	5
not at a all increased	slightly increased	don't know increased	fairly increased	highly increased

Part 3

Of the events that occurred during the supervision session, which ones do you feel were the most significant to you emotionally (positive or negative)? (i.e. learning - your confidence in transfer, and competence in clinical work)

- a)SPONTANEOUS:.....
- b)PROMTED:.....

8. What was the most significant emotional event (positive or negative) that occurred when trying to apply the supervision in the work place (i.e. transfer)?

.....

.....

9. Would you like to add any other comments before we finish the interview? In particular, is there anything else you would like to say about how clinical supervision might be revitalized? (How could it be even more helpful in developing your confidence or competence?)

.....

.....

.....

**Appendix 6 Consent form ATQ**

Background Information

**Instructions:** For the study of training and emotions some basic background information is needed about you. All these details will remain anonymous, and will only be used as part of an overall summary of information related to all of the delegates.

Gender (circle one)	MALE	FEMALE
Age (in years)		
Job title		
Qualifications		
Length of time worked in this or a similar job		
Dates of the PSI training that you attended		

.....



**Appendix 7 ATQ**

A. Think about the Psychosocial Interventions (PSI) training that you have received in the past three months. In relation to the PSI, please indicate how strongly you agree or disagree with each of the following statements by circling the appropriate number

1	2	3	4	5
Strongly Disagree	Disagree	Neither agree or Disagree	Agree	Strongly Agree

MOTIVATIONAL ASPECTS OF YOUR LEARNING

1. The training is effective with my clients

1 2 3 4 5
2. I think that the training was a valuable use of my time

1 2 3 4 5
3. The training is appropriate for my clients

1 2 3 4 5
4. I am keen to increase my competence in PSI (for example by learning from my mistakes)

1 2 3 4 5
5. I am keen to use PSI, so others respect the way I work (especially colleagues)

1 2 3 4 5
6. It's important to me to get it right, so other's approve of the standard of my work (including users)

1 2 3 4 5
7. The goals of the PSI training are achievable (for example the level of training is appropriate; the goals are sufficiently clear)

1 2 3 4 5
8. I am committed to the aims of the PSI training

1 2 3 4 5
9. I may give up if I am not initially successful with the PSI approach

1 2 3 4 5
10. If at first I can't do PSI as part of my job, I'll keep trying until I can

1 2 3 4 5
11. I see the PSI approach as having the "right" value base (for example empowering staff and treating users as partners)

1 2 3 4 5

COGNITIVE ASPECTS OF YOUR LEARNING

12. I have a sound knowledge of PSI

1 2 3 4 5
13. I know what I need to do to apply PSI

1 2 3 4 5
14. I think of PSI as a threat to my competence

1 2 3 4 5
15. I think that using the PSI training with my clients is an interesting challenge

1 2 3 4 5
16. If I encounter difficulties, I will consider different options for using PSI

1 2 3 4 5
17. I have coped with training like this before

1 2 3 4 5
18. I have applied similar training with my clients before

1 2 3 4 5
19. I know how I feel about PSI (for example positively or negatively)

1 2 3 4 5
20. Regulating my feelings or general mood helps me to learn about PSI, & to transfer it to my clients (for example improving how I

- feel by thinking positively or “dampening” a more excitable mood  
by calming myself down) 1 2 3 4 5
21. Sometimes I think I should be doing more in terms of PSI (e.g.  
using it more often) 1 2 3 4 5

#### RELATIONAL ASPECTS OF YOUR LEARNING

22. I talk with someone involved (for example a peer or supervisor) in  
order to get the most benefit from the PSI training 1 2 3 4 5
23. The teaching/learning environment is suitable physically (for  
example temperature; noise) 1 2 3 4 5
24. The organisation has systems in place to support PSI (for example  
supervision arrangements; steering group; audits) 1 2 3 4 5
25. The training environment feels safe (for example we all co-  
operate, and making mistakes is OK) 1 2 3 4 5
26. I felt that the atmosphere in the training session was warm and  
relaxed 1 2 3 4 5
27. I felt the trainer (tutor) understood the problems I faced (for  
example during the training or in applying it). 1 2 3 4 5
28. There are managers (& others) who support my PSI effort (for  
example “talking it up”/ champions) 1 2 3 4 5
29. My other colleagues at work support my participation in the PSI  
learning activities. 1 2 3 4 5

**B. AFFECTIVE ASPECTS OF YOUR LEARNING**

Below are some words that describe a range of feelings and moods. Please read every word carefully, then circle the number which best describes how often you have experienced each of these emotions during the PSI training (i.e. in the classroom situation).

1	2	3	4	5
Never	not very often	sometimes	fairly often	always

During the training how often have you experienced these feelings?

30.	affection (e.g. for a trainer/colleague)	1 2 3 4 5	39.	happiness	1 2 3 4 5
31.	anger	1 2 3 4 5	40.	fear	1 2 3 4 5
32.	anxiety	1 2 3 4 5	41.	gratitude	1 2 3 4 5
33.	boredom	1 2 3 4 5	42.	guilt	1 2 3 4 5
34.	confusion	1 2 3 4 5	43.	hopefulness	1 2 3 4 5
35.	excitement	1 2 3 4 5	44.	jealousy	1 2 3 4 5
36.	shame	1 2 3 4 5	45.	pride	1 2 3 4 5
37.	compassion	1 2 3 4 5	46.	relief	1 2 3 4 5
38.	envy	1 2 3 4 5	47.	sadness	1 2 3 4 5

Next, please go back & re-rate the above feelings for the work situation – i.e. how often have you felt any of these emotions in your routine work, when trying to apply /transfer the PSI training? This time, please underline the number above that best describes your feelings about PSI at work.

**C. COMMENTS/REMARKS**

From your own experience, what has been the single most important emotional event during the PSI training (positive or negative)?

.....  
Finally, please add any comments or remarks to either clarify your answers or to add any additional information on the emotional aspect of your PSI experience?

**Appendix 8 GQ**

**NEWCASTLE UNIVERSITY, CENTRE FOR APPLIED PSYCHOLOGY**

**Psychosocial Interventions training (PSI)**

**Self-rating of the generalisation of PSI training**

**Instructions**

Please insert the month your PSI course finished: .....Today's date:  
.....

This form is intended to obtain an estimate of the extent to which the PSI training has been transferred (or 'generalised') during or following the PSI course, to the benefit of clients or others.

The ratings should be based on the period since or during the initial 8 or 10 days PSI training course, and based on what you learnt during the course.

**A EXPERIENCE**

The following questions refer to your practical experience in the areas addressed on the course. For each item please answer by circling the number of your answer on this scale:

- 5        =        extensive application of these concepts in practice**
- 4        =        frequently use of these concepts in practice**
- 3        =        sometimes use these concepts in practice**
- 2        =        rarely use these concepts in practice**
- 1        =        never use this concepts in practice**

**Circle one answer**

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. The stress vulnerability model of serious mental illness     | 5 | 4 | 3 | 2 | 1 |
| 2. Systematic quantified assessment of clients and their carers | 5 | 4 | 3 | 2 | 1 |
| 3. Optimising the effects of medication                         | 5 | 4 | 3 | 2 | 1 |
| 4. Psychosocial family intervention techniques                  | 5 | 4 | 3 | 2 | 1 |
| 5. Cognitive behavioural management of stress                   | 5 | 4 | 3 | 2 | 1 |

**B. GENERALISATION**

The items below refer to the methods or instruments that you have learnt about during the PSI Course. First, please cross any of the number below to estimate your use of these methods in the 3 months prior to the course period:

- |          |          |                              |
|----------|----------|------------------------------|
| <b>5</b> | <b>=</b> | <b>extensive application</b> |
| <b>4</b> | <b>=</b> | <b>frequently use</b>        |
| <b>3</b> | <b>=</b> | <b>sometimes use</b>         |
| <b>2</b> | <b>=</b> | <b>rarely use</b>            |
| <b>1</b> | <b>=</b> | <b>never use this</b>        |

- a. KGV (mental state)
- b. SFS (social functioning)
- c. Analysis of emotions
- d. Identifying antecedents
- e. Analysing consequences
- f. Formulation chart ("flow chart")



- g. Use of graphs with clients
- h. Beck’s instruments (e.g. BDI., BAL or Hopelessness Scale)
- i. FMI (family member interview)
- j. Anxiety management
- k. Depression management
- l. Coping strategy enhancement
- m. early intervention paperwork
- n. Any others? - please list all that you have applied with your clients:
- o. ....
- p. ....
- q. ....

Now please circle any of the number to estimate how much you have used them in the 3 moth since the PSI course.

**C. CLINICAL EFFECTIVENESS**

Using the above PSI methods may or may not have been of benefit to your clients. Please estimate your clinical effectiveness (i.e. impact on client outcome) by circling the appropriate number on this scale:

- 1 = **NO IMPACT**/ some undesirable consequences for my clients (i.e. no-one benefiting).
- 2 = **SMALL IMPACT** - some sign that the PSI methods have been clinically effective (e.g. 1% - 25% of clients benefiting).

3 = **MODERATE IMPACT** - some clear indications that your clients' are benefiting (e.g. 26% - 50% clients benefiting).

4 = **SIGNIFICANT IMPACT** - clearer impact for more clients (i.e. 51% - 75% benefiting).

5 = **LARGE IMPACT** - very clear impact for most clients (i.e. 76% - 100% of clients).

With approximately how many clients have you applied the above PSI methods during the past year? ☐ (No. of Clients)

**Appendix 9 DCD**

Clinician’s Daily Coping Diary

Name: \_\_\_\_\_

Today’s Date: \_\_\_\_\_

**Introduction:** Remember the purpose of this study is how you cope with the daily demands of transferring ideas from mentoring/supervision to your routine work (e.g. PSI methods). Please try to complete the diary for every working day and do so within 24 hours.

A. STRESS

Please think about your role as a Clinician, trying to transfer ideas. In relation to this, please circle the number that best represents the degree of stress you have felt today;

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

B. COPING

2. How have you handled this stress today? This may include things that happen away from work (e.g. at home). Please consider each of the following methods, and rate each of those you have used, again by circling on the lines below, the number that best represents the frequency with which they have been used:

a) Diverted attention away from the stress by thinking about other things or engaging in some activity (avoiding the problem).

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

b) Tried to see the stress in a different light that made it seem more bearable.

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

c) Thought about solutions to the stress, gathered information about it or actually did something to try to solve it.

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

d) Expressed emotions in response to the stress to reduce tension, anxiety or frustration.

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

e) Accepted that the stress had occurred but that nothing could be done.

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

f) Sought or found emotional support from loved ones or friends.

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

g) Did something with the implicit intention of relaxing.

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

h) Sought or found spiritual comfort and support.

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

i) Did you use any other method of coping? eg, supervision, case discussion etc ,If so, write it here and again rate it:

Method = \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10
Not at al					All the time				

C. STRAIN/MASTERY

Below are some words that describe a range of feelings and moods. Please tick any which describe feelings you have experienced today, while attempting to cope with the stress (e.g. while attempting to transfer ideas from supervision/mentoring or while working with clients). Remember, this may include things that happen away from work, within a 24 hour period.

affection	<input type="checkbox"/>	happiness	<input type="checkbox"/>
anger	<input type="checkbox"/>	fear	<input type="checkbox"/>
anxiety	<input type="checkbox"/>	gratitude	<input type="checkbox"/>
boredom	<input type="checkbox"/>	guilt	<input type="checkbox"/>
confusion	<input type="checkbox"/>	hopefulness	<input type="checkbox"/>
excitement	<input type="checkbox"/>	jealousy	<input type="checkbox"/>
shame	<input type="checkbox"/>	pride	<input type="checkbox"/>
compassion	<input type="checkbox"/>	relief	<input type="checkbox"/>
envy	<input type="checkbox"/>	sadness	<input type="checkbox"/>

Please specify any others (e.g. frustration) \_\_\_\_\_

Now please circle the number that best represents how you have felt overall today, related again to your efforts to transfer ideas:

1	2	3	4	5	6	7	8	9	10
Felt very distressed (e.g. lots of anger and no good feelings)					Felt very good (e.g. sense of coping well, of mastering things, proud happy...)				

D. TRANSFER

The items below refer to the methods or instruments that you have learnt about and/or been encouraged to use in mentoring/supervision.

A. Please tick any you have used in any way (e.g. simply introducing the rationale for a PSI method, processing it for action, or applying a PSI method).

- ☐ KGV (assessment of symptoms/mental state)
- ☐ SFS (social functioning)
- ☐ Identifying antecedents (as part of ABC assessment)
- ☐ Defining “target” or important behaviours (as part of ABC assessment)
- ☐ Analysing consequences (as part of ABC assessment)
- ☐ Formulation chart (“flow chart”)
- ☐ Use of graphs with clients
- ☐ Beck’s instruments (e.g. BDI, BAL or Hopelessness Scale)
- ☐ FMI (family member interview)
- ☐ Anxiety management (e.g. hierarchy development; desensitization)
- ☐ Depression management (e.g. CBT techniques, such as activity scheduling)
- ☐ Coping strategy enhancement (e.g. problem-solving; social skills training)
- ☐ Early intervention work
- ☐ Medication management
- ☐ Other; please specify \_\_\_\_\_

Please circle the number that best represents how often you have used (or planned/considered using ) these techniques today.

1	2	3	4	5	6	7	8	9	10
Never used					Extensive application				

E If you wish, please make any comments here:

